STORAGE

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DETROIT MEDICAL JOURNAL

The Practitioner's Monthly

CONTENTS:

ORIGINAL

Hackley Hospital—A Model for Small Cities. By FRANK W. GARBER, M. D. Muskegon. 1

A Case-History Clinic. By RICHARD C. CABOT, M. D., Boston - - - - - - 6

The Differential Diagnosis and Treatment of the Chronic Non-Tubercular Joint Diseases. By WM. E. BLODGETT, M. D. Detroit 13

CLINICAL REPORTS

Pulsating Exopthalmos with Successful Ligation of Carotid. By MAX BALLIN, M. D., Detroit - 20

Complete Inversion and Prolapse of the Uterus. By J. A. MAC MILLAN - - - - - - 21

TRANSACTIONS OF SOCIETIES

Detroit Academy of Medicine 22

Wayne County Medical Society 22

EDITORIAL

The Medical Service of the Japanese Army. - - - - 23

Appendicitis and Progress. By B. R. SCHENCK, M. D. - - 24

Hospitals for Small Cities. - 25

Clinical Reports - - - - 25

Detroit Post-Graduate School 26

MEDICAL PROGRESS.

Triplets in Uterus Bicornus - 29

Museum in Medical Teaching 29

Use of Dionin - - - - - 29

Resection of Nasal Septum - 30

Prognosis of Epilepsy - 30

Cerebro-Spinal Meningitis - 30

News - - - - - - 26

New Instruments

New Head-Lamp—Illuminating Outfit—Tenaculum Forceps—Oertel's Stethoscope - - - - 31

Book Reviews - - - - 33

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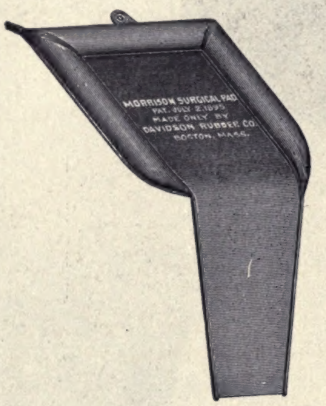

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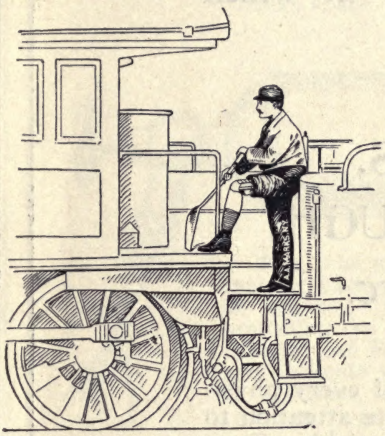

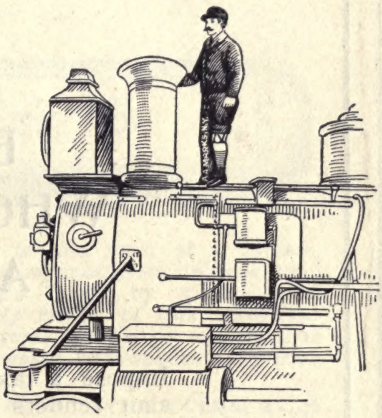

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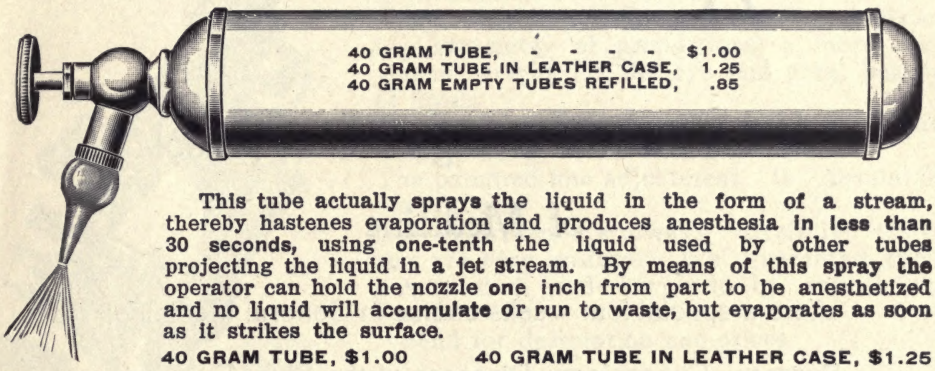

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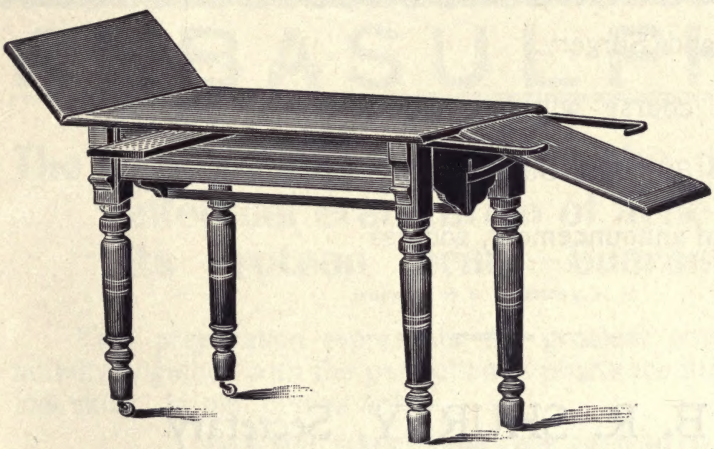

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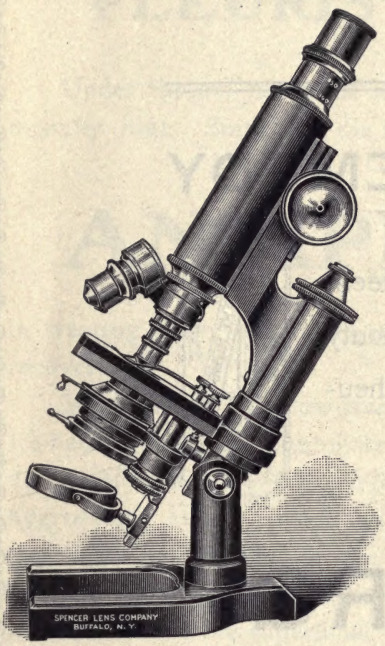

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INDEX TO ADVERTISERS.

Albasulphidi VII
Ambulatory Pneumatic Splint.....XIX
Antikamnia Chemical Co. XVIII
Antiphlogistine (Denver Chem. Mfg. Co.) IX
Armour & Co.....XIV
Avena-Pharmacal Co.....XVIII
Bausch & Lomb.....XXV
Becton, Dickinson & Co.....XXI
Bovinine Co.....Inside Front Cover
Bristol-Myers Co.....XVII
Castle, Wilmot & Co.....III
Chesterman & Streeter.....XII
Chloride of Silver Dry Cell Battery Co ..XII
Clark & Roberts.....XXII
Cleveland Leather Goods Co.....XXII
Codman & Shurtleff.....XXII
Columbus Aseptic Furniture Co.....XX
Crittenton, Charles N. Co.....XIV
Davidson Rubber Co.....II
Fellows, Mr.....XXVIII
Fries Bros.....XIX
Gebauer Chemical Co.....V
Globe Mfg. Co.....XIX
Goodrich, The B. F. Co.....XXIV
Grosvenor & Co.....XI
Hartz, The J. F. Co.....V
Hastings & McIntosh Truss Co.....XII
Hussey, E. J. & Co.....XXII
Jones of Binghamton.....X
Kny-Scheerer Co.....XXVI
Kutnow Bros., Limited.....XXVII
Kress & Owen.....I
Lambert Pharmacal Co.....Back Cover
Lee, J. Elwood Co.....X
A. L. Massey & Co.....VIII
Marks, A. A.....III
Marvel Co XXVI
D. P. McElliott.....XXVIII
Merrell, The Wm. S. Chem. Co.....
.....Inside Back Cover
Edward Pennock.....XXIV
Scheidel, W. & Co.....XXVI
Sidway Mercantile Co.....XII
Smith, M. H. & Co.....IV
Spencer Lens Co.....VII
Stearns, Frederick & Co XV
Swett & Lewis.....XXI
Tagliabue, Charles J.....XXV
Upjohn Co.....XIII
Victor Electric Co.....XXIII
Wabash R. R.....XIX
F. E. Young & Co.....XXVIII

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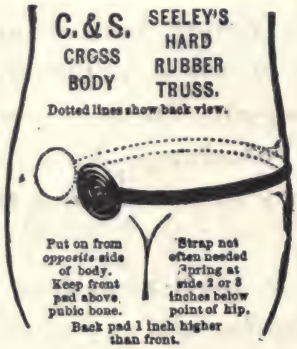
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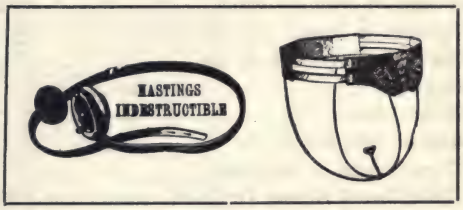

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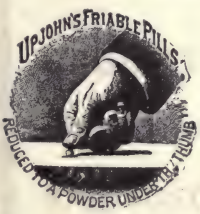

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THE DETROIT MEDICAL JOURNAL.

VOL. V. APRIL, 1905. NO. 1.

HACKLEY HOSPITAL—A MODEL FOR SMALL CITIES.

FRANK W. GARBER, M. D.
Muskegon, Mich.

One of the first things that strikes the eye on entering the Hackley Hospital is a brass tablet bearing this inscription, "Established May 28th, 1902, by Charles H. Hackley, for the relief and cure of the sick and suffering, and *for the promotion of Medical Science.*" The fact that one of the prime objects of this magnificent institution is the furtherance of medical knowledge makes it of especial interest to physicians. While broad in its charity and true to its purpose to relieve the sick and suffering, it does not seek to do so at the expense of the physician, as so many of these charities do, but has manifest the most liberal policy toward the profession from the start. Two of the nine trustees are physicians. The staff embraces practically every doctor of medicine in the city, the purpose being that all shall share its advantages and grow with its growth.

Such an institution as this the profession of Muskegon has long desired, and when Mr. Hackley announced in the spring of 1902 that he would build and equip a hospital, the physicians of the city went to him in a body to express their gratitude and to pledge their support. His unstinted liberality to Muskegon in the way of manual training school, library, parks and monuments, to which he had given over one and a quarter million of dollars, led us to expect much and we have not been disappointed. Beside the endowment of $100,000.00, the hospital and grounds have cost over $200,000.00.

Having determined the size of institution demanded by a city of Muskegon's population, the only restriction placed upon the trustees has been, "get the best of everything."

Hackley Hospital is built on the pavilion plan, there being really four buildings in one. It occupies four city blocks, thus giving ample room for expansion and providing recreation and breathing place for convalescents. It has an extreme length from east to west of two hundred and four feet, and is composed of a central administration building which faces the north and connected on either side by wide corridors are the east and west pavilions which are devoted to wards and private rooms for patients. Back of the administration building is the service building in which are the kitchen, dining rooms for help, the laundry, and the power, heating and lighting plant. The buildings are constructed of the best material and are as nearly fire proof as modern construction can make them. The outside walls are of red pressed brick with foundation and trimmings of Bedford stone. The roof is a red tile. The building is so placed that every room has sunshine at some hour of the day.

As one enters the administration building he is ushered into a spacious

lobby well lighted from either side. To his left is a finely furnished reception room and the trustees room in which are also held the meetings of the staff. This room has a carefully selected medical library, containing the latest and best works on medicine, surgery and the collateral sciences. Across the corridor and still to the left of the lobby are the pathological and bacteriological labratories which are equipped with the latest devices for the careful carrying out of this work. To the right of the lobby are the superintendent's and clerk's offices, while just ahead and to the right is the pharmacy. The corridor leading to the left as we enter takes us to the men's wards, medical and surgical. These are spacious and well lighted rooms, having six beds each with a capacity for four more in each ward. Here are also diet kitchen, nurses' room, convalescing room, bath and toilet rooms. The second floor of this pavilion is an exact reproduction of the first and is used for women. Coming again to the lobby on the first floor of the administration building and passing down the corridor to the right of the entrance we reach the west pavilion. This floor of the pavilion is devoted to private rooms and a solarium. The service rooms are similar to those in the east pavilion.

HACKLEY HOSPITAL—Front View

On the second floor of this pavilion are the obstetrical wards, the children's ward and private rooms for obstetrical and gynecological cases, delivery room and service rooms with a solarium to the south.

The second floor of the administration building contains rooms for the officers, dining-room, and sewing room. Beyond this and over the service building to the south, but wholly disconnected, are the isolation wards for contagious cases. On the third floor of the central or administration building are the main operating room and the septic operating room. The main operating room is probably not surpassed by any in the country. It is the best product of the best and latest thought. It is spacious and perfectly lighted by day or by night. Its equipment is right. To the left, as we approach the main operating room are the static electrical room, nurses' room,

the sterilizing room and the supply room. On the right are the etherizing room, the recovery room, surgeon's room, the X-ray room and the septic operation room. This floor is reached by stairway and by a large automatic electric elevator. To the back of the elevator shaft on the first floor of the administration building is the reception room for ambulance patients and the emergency operating room.

In the basement is a complete department for hydrotherapeutic work. Much attention has been given to the equipment of this department and it is believed that few hospitals are so well fitted for carrying out the details of this important branch of therapeutics.

The foregoing gives briefly the main feature of the hospital. Plans are now in the hands of the architect for a nurses' home to cost $20,000. This building will be built just to the west of the hospital and will harmonize with it in its architectural features. It will be two stories in height and contain twenty-four rooms for nurses besides the lecture rooms, sitting room and dining room. It is designed to have it connect with the main building by an underground way.

To the back of the main building is the morgue which is especially equipped for anatomical study and for experimental surgery upon the cadaver.

The title to the Hackley Hospital and the annexed buildings and grounds is vested in a board of nine trustees, the election of which board was placed by Mr. Hackley with the First Congregational church of Muskegon. While the control of the property is thus primarilly with this religious body, the hospital is in no sense denominational. Three members of the board of trustees are chosen each year for a period of three years. The detail work of this board is done by an executive committee, a committee on buildings and grounds, and one on the training school for nurses. Its meetings are held monthly. By them the medical staff is chosen, the superintendent and other employes. Large discretion is given the superintendent who works more directly under the executive committee with the board a court of final resort.

The staff is appointed for one year, but any member may be removed for unbecoming conduct after an appropriate trial before the expiration of that term. Five departments have been created with a chief of staff over all and a head of each department. At the head of the staff is Dr. J. Vanderlaan. Dr. Vanderlaan is also head of the medical department. Associated with him are Drs. S. Bloch, C. L. Thompson, J. G. Jackson, H. A. Cummings, P. A. Quick, E. G. Appleton, C. Thomas and L. R. Marvin. The department of surgery has for its head Dr. F. W. Garber with Drs. G. L. Le Fever, J. F. Denslow, J. Vanderlaan and F. B. Marshall associated. The department of gynecology has Dr. L. R. Marvin for its head, aided by Drs. G. S. Williams, L. I. Powers, F. W. Garber and J. A. Fleming. At the head of the department of obstetrics is Dr. B. D. King and associated with him are Drs. L. I. Powers, G. S. Williams, C. L. Thompson and W. A. Campbell. The department of pediatrics is under the headship of Dr. L. I. Powers with Drs. F. L. Marvin, C. J. Durham, R. G. Oleson and G. J. Hartman as associates.

The following gentlemen are appointed for special work:

Anæsthetist, Dr. A. A. Smith; Pathologist, Dr. O. C. Wicks; Bacteriologist, Dr. L. N. Eames; Electro-therapist, Dr. J. Osting; Hydrotherapist, Dr. J. P. Sullivan; Eye and Ear, Dr. V. A. Chapman; Nose and Throat, Dr. J. O. Bates; lecturer on Anatomy and Physiology, nurses' training school, Dr. W. A. Campbell; Materia Medica, Dr. R. G. Cavanagh; Bacteriology, Dr. O. C. Wicks.

A consulting staff composed of the following out-of-town physicians has also been appointed:—Dr. A. Vanderveen, Grand Haven; Dr. Henry Hull, Ravenna; Dr. B. F. Black, Holton; Dr. Geo .W. Nafe, Fremont; Dr. Frank W. Wilson, Shelby; Dr. Chas. F. Smith and Dr. L. N. Keyes, Whitehall; Dr. L. E. Jones, Montague; Dr. Hatch, Hart; Dr. Allen, Pentwater, and Dr. Rollison, of Hesperia; Dr. B. F. Baldwin, North Muskegon.

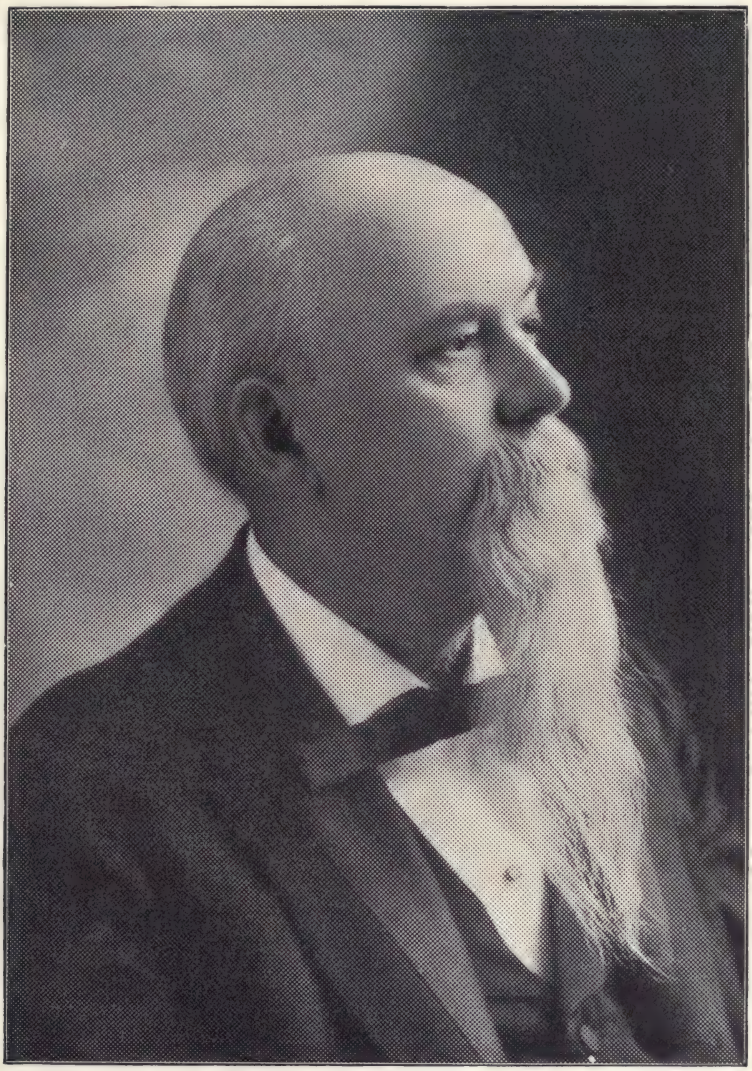
The superintendent of the hospital is Miss Clara W. Dyring, who is also principal of the training school. The latter department is not yet fully organized. It contemplates a three years' course and the admission of those only who have had a high school course or its equivalent. It is proposed to make the work of this department equal the best, and a most careful selection of applicants will be made.

HACKLEY HOSPITAL—Side View

This description of Hackley Hospital would hardly be complete without a brief sketch of the donor. While yet these lines were in preparation Mr. Charles H. Hackley passed on. The end came almost without warning February 10th, 1905. It is perhaps too early to form a just estimate of this simple mannered, great hearted friend of ours, but it is not too early to say that his death is felt as a personal loss by every citizen of Muskegon. With large wealth at his command, he lived without ostentation. For himself the simpler things of life sufficed. For his fellow citizens he was satisfied with the best only. Living with less display than many men of moderate means, he gave with lavish hand to the institutions which he founded and which have become an enduring part of our civic and social life.

Coming to Muskegon in 1856 a penniless youth of nineteen, by his own brain and brawn he early laid the foundations of that large fortune which

he so wisely used for the benefit of his fellow citizens. He identified himself at once with the lumber industry, and while his interests have since taken a wide range, he was always a lumberman. Taking a keen interest in poli-



THE LATE MR. CHARLES H. HACKLEY

tics, he never cared for office. As a member and as president of the board of education of Muskegon, he was long identified with educational matters and it was in this direction that his earliest and in many ways most helpful benefactions were bestowed. How many and how varied these have been let the following record show:

Hackley Public Library (1888)	$ 155,000
Endowment (1891)	75,000

Hackley Manual Training School and Gymnasium (1895, 1900)	220,000
Endowment (1902, 1904)	400,000
Additional funds in maintenance of the school from its opening in 1896	50,000
Hackley Park and endowment (1890)	60,000
Soldiers and Sailors' Monument (1889)	27,000
Statues of Abraham Lincoln, Ulysses S. Grant, William Tecumseh Sherman and David G. Farragut (1898)	26,000
Statue of Phil Kearny (1901)	5,000
Statute of William McKinley (1902)	15,000
Home of the Friendless Endowment (1902)	25,000
Hackley Hospital (1902)	220,000
Endowment (1904)	100,000
Athletic Field for High School (1902)	5,000
First Congregational church debt	6,525
Total	$1,389,525

The foregoing donations were made during Mr. Hackley's life. By his will he has added $200,000.00 to the endowment fund of the hospital, $210,000.00 to the manual training school; $250,000.00 to the Hackley library; $15,000 to the Muskegon Humane Union, and an additional $2,000,000.00 to be given on the death of Mrs. Hackley. The city thus becomes the recipient of his bounties to the extent of over $4,000,000.00.

159 Jefferson St.

A CASE-HISTORY CLINIC.*

RICHARD C. CABOT, M. D., Boston, Mass.

(The following stenographic notes are a record of a demonstration by the author of a method of clinical instruction used by himself at the Harvard Medical school. No patient was present. Typewritten slips containing the case-history as given below, were distributed among the students. It was taken for granted that the physical examination had been made, clinical and laboratory findings, and the history all known. With these at hand, the class is led to deduce the diagnosis, prognosis and treatment. The great interest of this method and its value to the class is shown by the following report. The notes on one case have been deemed sufficient. —S., here means student.—Editor.)

"A factory overseer, 63 years old, had been subject to constipation for five years, and for two years had had righ inguinal hernia. Otherwise his antecedents from a medical point of view were excellent. On the day before his illness he had what he regarded as a satisfactory movement of the bowels. That night he ate heartily of clam-chowder and strawberries. The next afternoon he felt some abdominal discomfort. Later, while taking a bath, he found his hernia was down (as he had taken the truss off), and he found more difficulty than usual in replacing it. That night he vomited a great many times, the first vomitus suggesting strawberries, and he had great abdominal pain, diffuse, not localized. At 4 the next morning, when seen for the first time, he was not collapsed. The tongue was moist, with a slight white coat. Temp. 98.4, Pulse, 60, Respiration, 14. The abdomen was soft, not tender. The hernia was found to be perfectly reduced. Nothing abnormal was felt per anum. The pain required an injection of ½ grain morphia. Nausea

*Given before Dr. Dock's clinic, University Hospital, Ann Arbor, March 21, 1905.

was so troublesome that the patient refused even bits of ice. (Nothing whatever passed the bowels.) On the second day the vomiting became stercoraceous. On the third day the vomiting persisted. Temp. 98.5, Pulse, 68. Large enemata (5½ quarts), had been given three times without apparent benefit. The belly was distended, rather hard, not tender. In the right side an ill-defined resistance seemed to be felt, corresponding to the ascending colon. A consultation was now called. What would have been your diagnosis, prognosis, and treatment?"

Mr. Barnett. You note that the respiration is 14. What comes to your mind as a possible cause for that respiration? The best way when confronted with a fact of this kind is to think what are the causes of slow respiration any way, and then go through the different causes and see if any of them will fit this case. We know of a great many things which cause rapid respiration, but unfortunately, I asked for those of slow respiration a question much less easy to answer. S.—Toxaemia. Dr.—What are the effects, of toxemia for instance, in typhoid and uræmia? S.—The first effect is to increase the respiration. Dr.—Yes, that is the usual effect; what other? S.—It starts with a slow respiration and works up to a climax, and then goes down again. Dr.—Then it is a rhythmical increase and decrease of the rate and depth of respiration, followed by a period of apnœa, i. e., when there is no breathing at all. What are some of the causes of that? S.—You get it in a good many acute respiratory disorders, such as pleurisy. Dr.—Not often in pleurisy, but in what other acute infection? S.—Pneumonia. Dr.—Yes, and that is one of the times when it does not mean death. You think of it chiefly as a prognostic sign; you see it and you know death is near, but in pneumonia you see it, and yet the patient may get well. S.—You see it in nervous disorders. Dr.—I think it is mostly in brain tumor, meningitis and organic brain diseases of that kind. Mr. Bower, can you tell me of any condition in which a patient may have Cheyne-Stokes and yet be normal? When does it occur in health? S.—It occurs in young children when they are asleep. Dr.—Yes, if you watch you will see Cheyne-Stokes under those conditions. It is commoner than we often suppose; we ordinarily look for it only when people are sick. But we are far afield from our original point. Why has this patient got slow breathing? S.—If he has much abdominal pain the breathing might be slow. Dr.—Well, it might be restrained, but would it necessarily be slow? In peritonitis, for example, do they have slow breathing? No; shallow and of a costal type. Is there any possible cause of that respiration 14? S.—I don't know of any other causes. Dr.—Well, we have not mentioned any yet. S.—Abdominal tenderness. Dr.—I don't think that is a cause of slow breathing. It is a cause of shallow breathing or costal breathing but not slow breathing. S.—The time of day would have something to do with it. Dr.—What time is it slowest? S.—Early morning. Dr.—What time of day is it quickest? S.—In the evening. Dr.—It is slow in the early morning hours and quickens as the day goes through. Any other cause? S.—The slow pulse rate. Dr.—I don't think I can agree with that. One has a great many cases of slow pulse rate that don't produce slow breathing. S.—You get slow breathing from poisonous vapor. Dr.—You get it occasionally in gas or shock. The question is, whether this case is due to shock. S.—Some drug perhaps. Dr.—What drug could produce slow

breathing? S.—Morphine. Dr.—How do you know he hasn't had morphine? The first question you should ask yourself is, Has he had morphine? I brought that point up because if you were confronted with a case in that way, the first question you ought to ask is, Has he had morphine? And, in fact, this patient had had morphine, and that was the cause of his slow breathing.

Dr.—Now the temperature was 98.4 on two occasions and 98.5 on the third day. The question is, what important information do we gain in this case from that fact? What does it enable us tentatively to exclude? S.—It would exclude any acute infection. Dr.—Such as— S.—Peritonitis. Dr.—

If it continues normal it is against peritonitis. I would not say that a normal temperature might not occur in general peritonitis. What temperature would you expect? S.—Possiply 102 or 103. Dr.—What would you expect with a typhoid case just after perforation. Suppose a typhoid ulcer had perforated, what temperature would you expect? S.—It would be subnormal. Dr.—General peritonitis has a period of low temperature immediately following the occurrence of its cause. But this is neither sub-normal nor raised and so tends to make us think he hasn't got general peritonitis.

What do you think about the strawberries? You see, his symptoms immediately followed the eating of clam chowder and strawberries. What do you think about that combination of food? S.—If they got down to the region of the hernia they might have constricted it but since they were vomited they are probably not of importance. Dr.—If they cause trouble, what kind of trouble would they have been likely to have caused? S.—Strangulation of the hernia. Dr.—Or strangulation of the gut. Do you know any case on record of that? I do not know of any case on record, but I never like to deny anything of that kind because if I tell my students it can't happen they bring me a reference where it did—I am learning lots from them all the time—but unless you have some reference of that kind in your mind, I think we can say that strawberries have not yet produced that condition. What effect might they have? S.—They might cause acute indigestion. Dr.—What then would probably be the state of his bowels? S.—They would be loose. Dr.—As to the number of movements, were they more or less than before? S.—After the strawberries, less. Dr.—They would probably not lock up his bowels. Apparently this man's bowels used to move; after eating the strawberries they did not move; ordinarily they don't produce that effect, so that it becomes difficult for us to connect them with this event and yet we can't help noticing that the trouble immediately followed that.

Now, I think it is time to suggest some possible diagnoses. What diagnosis seems one of those possible in this case? S.—Intestinal obstruction.

Dr.—We certainly must consider that as a diagnosis whatever we finally think about it. What suggests it? S.—The constant vomiting. Dr.—That is, whenever a man has constant vomiting you think of intestinal obstruction. Would you? S.—No; when there is fæcal matter or stercoraceous vomiting. Dr.—That is suggestive of obstruction? Yes, what else causes the vomiting of stercoraceous material? [No answer.] Well; there are two

common causes, intestinal obstruction and general peritonitis. They are the two common causes, and in respect to that symptom are practically the same thing, for general peritonitis produces obstruction by paralyzing the bowel. General peritonitis has got to be thought of in this case. There is a good deal against it, but we have got to consider it.

Dr.Beside stercoraceous vomiting, what else is in favor of intestinal obstruction? S.—Hernia. Dr.—Anything else? S.—That there was no passage of fæces. Dr.—The fact that his bowels didn't move. First the bowels didn't move, then the stercoraceous vomiting, then the hernia.

Dr.—Now is there any other possible diagnosis? S.—I think appendicitis ought to be considered. Dr.—Would you have to add anything to that diagnosis? Could simple appendicitis produce these symptoms or would you have to say appendicitis plus something else? Would a case of simple stercoraceous vomiting indicate appendicitis? S.—Plus peritonitis. Dr.—Yes; you would have to put that down complicating appendicitis.

Dr.—Is there anything else? S.—I should think obstruction of gall stone. Dr.—What suggested that to your mind? S.—The acuteness of the pain. Dr.—Yes, what else? S.—The tendency to slow pulse and slow respiration. Dr.—Yes, if there were jaundice in the case that would explain the slow pulse, although it is not extraordinarily slow. But what connection is there between gall stone and intestinal obstruction? S.—Gall stone may produce peritonitis, and so bring about obstruction. Dr.—Yes, that is one connection. What other connection between gall stone and intestinal obstruction beside the fact that the gall stone ulcerating through may give peritonitis? Suppose we had 500 small gall stones in gall bladder, would that produce internal obstruction? S.—I think it might. Dr.—No, it never does. S.—A large stone may perforate directly into the intestine; it is not a very rare case. Dr.—Right. It is a very hard thing to picture to yourself because gall stones seem so small compared to the diameter of the intestine. If the intestinal obstruction is due to gall stone, where would the intestinal obstruction be? S.—In the transverse colon. Dr.—What is the difficulty of its being in the transverse colon? S.—It wouldn't be so likely to ulcerate through into the colon. Dr.—Yes, it might be in such a position that this could happen. S.—The transverse colon is so much larger than the small intestine. Dr.—It is almost unknown to have a gall stone large enough to obstruct it; therefore, if due to gall stone it is probably in the small intestine or duodenum. Now we have reason here to know that this obstruction, if it is obstruction, is not in the small intestine and not in the duodenum. Can any one see what reasons we have for believing that it is not in the small intestine? S.—The physical examination gives a mass which seems to correspond to the position of the ascending colon. Dr.—Now any other reason? S.—The vomiting would have come sooner. Dr.—How soon did it come? S.—The second night after he had eaten the strawberries and clam chowder. Dr.—There seemed to be about twenty-four hours between the beginning of the symptoms and the beginning of the vomiting, and that would be a point against the occurrence of obstruction in the small intestine. Can anybody tell me whether the symptoms are apt to be more acute and more severe if obstruction occurs in the small intestine or in the large?

Which kind givest the severest symptoms? S.—The small. Dr.—Yes, they are usually worse within a short time than obstructions in the large intestine, and there was another point which we took account of in the beginning. What was that? S.—The pulse and temperature were normal on the third day. Dr.—Yes; that the pulse and temperature were practically normal the third day means obstruction in the large intestine, if anywhere.

Now are there any other possible diagnoses that we want to put down? Does anyone think of anything else? S.—Toxic poisoning from the fruit. Dr.—Well, we have discussed that more or less. The difficulty is that toxic poisoning almost always gives us diarrhœa. I have never heard of any case of intestinal obstruction following toxic poisoning from food. S.—Are we sure the hernia was reduced? Dr.—I am glad you brought that up. S.—It might have been just reduced in mass. Dr.—Tell me more about that. S.—I think it easily happens in an attempt to reduce hernia that not only the intestine but ring and all are shoved into the abdominal cavity. Dr.—Do you think that happened in this case? S.—Why, I think the temperature remaining at 98.5 and the pulse 68 the third day is rather against it. Or.—Has any one any other opinion as to the condition of that hernia? What is the likelihood that that went up into the belly without being reduced? Of course, we have no very positive evidence on that point; but it is evident, in the first place, that he had been in the habit of having his hernia come down and putting it back and, although it went back with more difficulty than usual, there was not so much difference as you would expect. In those cases where the whole mass is shoved back without being reduced, great force is used, and here where the patient has reduced it himself you have no reason to suppose anything of that kind.

Dr.—Is there any other diagnosis? My class in Boston insist we shall consider hysteria. I have got in the habit of considering hysteria with everything, because there is no disease almost that it can't simulate; but, I must say, I could not produce any evidence that hysteria has ever produced stercoraceous vomiting. The other symptoms could very easily be reduced to hysteria, except that one would have to explain this mass on the right side of the abdomen. What could we do to explain that? S.—It might be a muscle. Dr.—Yes, again and again I find myself deceived by what turns out to be a rectus muscle. What could you do to be sure? S.—You could examine it in a warm bath. Dr.—Yes, that would be much better than examining it under anaesthesia. Does any one know any other test for diagnosing a rectus muscle from a true abdominal tumor? [No answer.] You have the patient lie on a table and raise his head while your hand is on the supposed mass and if the mass is muscle it thickens up instantly. That is pretty good as a preliminary test; any tumor which becomes more prominent when the patient raises his head is likely to be rectus muscle. What else might it be, if not rectus muscle? S.—A floating kidney. S.—A phantom tumor. S.—The presence of gas. Dr.—Yes, but of what organ or what viscus? Sometimes in connection with a dilated colon one gets very large "phantom" tumors which appear as the gas is set free; it might be a mass of fæces, although they almost always have a stricture ahead of them if they accumulate. But it does not seem to me, on the whole, necessary to consider hysteria.

Now, our time is short and though there are many other points to discuss I shall have to stop and take a vote between these two diagnoses (on blackboard: 1. Intestinal Obstruction. 2. General Peritonitis), how many vote for the first? How many for the second? It seems to be unanimous for the first, and I agree with the majority. And if it is intestinal obstruction, where is it and what is it due to?

We have already discussed a little the question where it is. It seems much more likely that it is in the large intestines because the symptoms are not so acute, and from the position of this mass which seems to correspond to the ascending colon. Now whereabouts is it? S.—In the ascending colon? Dr.—This mass may be what? S.—Fæces. Dr.—Yes; if it were a mass of fæces then the obstruction would be where? Either in the transverse or ascending colon or where else? S.—The sigmoid. S.—The hepatic flexure. Dr.—Of course, the whole mass might be malignant disease, but it is a pretty large mass for malignant disease. If it is in the large intestine and in the neighborhood of the hepatic flexure, what is it most likely to be due to? S.—It might be intussusception. Dr.—What is the common age for that? S.—It is found in children. Dr.—This, then, is not a common age for it. S.—The obstruction may be due to previous operation. Dr.—That is a common cause, bue we have not had any evidence that he has had a previous operation. Is there any other possibility of a cause for this obstruction? Now, taking just the fact of his age, what is the common cause of intestinal obstruction at his age? S.—It might be due to stricture. Dr.—Of what nature? S.—Twist. Dr.—Twist is a race cause. What is more common at his age? S.—Ulcer. Dr.—That is rather rare. S.—Hernia. Dr.—Yes. S.—He may have a neoplasm. Dr.—Yes, that is about five times as common as any of the rest of those; at this age, 63, your snap diagnosis should be malignant disease. Now, if it were malignant disease, how could it have produced acute obstruction in this way? That is the difficulty that occurs to you. Malignant disease is a slow growing process; this apparently came on acutely? Is there any way to reconcile these facts? S.—He may have been constipated for some time and then there may have been acute spasm. Dr.—Well, an element of spasm might have come in by reason of excessive peristalsis; but what would suggest a possible cause for increased peristalsis? S.—The strawberries. Dr.—Yes. We have wanted all along to get the connection that the strawberries and clam chowder have with this case, and you suggest a possible way of associating them. Malignant disease may exist for a long time in the large intestine and give no sign of its presence; and then some acute cause like this may set up peristalsis and tighten up the stricture so as to cause this acute obstruction. Again and again I have seen malignant disease of the intestine come on just as this has because some particular cause like the strawberries and clam chowder made the stricture shut down. Now, what further examination would help you at all in determining the nature of this obstruction? Is there anything else you could do so as to be any surer as to what this thing is? S.—If you could get a movement of the bowels, you would haye a chance to examine stools. Dr.—How would you advise us to get that movement? S.—You might give a cathartic. Dr.—What cathartic would you give? S.—I would not give any.

Dr.—That's right, but how would you get it? S.—You might try hot applications. Dr.—Enemas have already been tried. S.—You might try some more. Dr.—Would you suggest any different kind of enema? Could you think of any other kind that could be given? S.—You might give a high enema, with a stimulant, such as turpentine. Dr.—It is occasionally worth while to try the high enema with oil, but it seems to me as if they had given a pretty fair trial to enemata here. They got in 5½ quarts. How high would that go. S.—I should think that would go through the descending and transverse colon. Dr.—Yes, one can tell by that fact that the obstruction is not low down. Would blood examination help you any? S.—I think so. Dr.—What would you do? S.—Look for a leucocytosis. Dr.—How would that help you? S.—In a case of malignant disease anemia would be present. Dr.—I don't think it would be likely to help you; malignant disease might have produced an anemia, but his previous history was stated as excellent, so he would not be likely to be anemic. Would the urine examination help you any? S. Indican. Dr.—What would that tell? S.—It would show that there was intestinal obstruction. Dr.—What else beside intestinal obstruction will give you an increased amount of indican? Aren't there a good many other conditions where indican is increased? S.—It might be due to constipation. Dr.—What kind of intestinal obstruction increases indican? S.—When you have any putrefactive changes. Dr.—And if intestinal obstruction, what kind would be most likely? S.—It would be far down in the intestine. Dr.—What do you think about that? You think it is usually obstruction high up? How many think it is low down. How many high up? The majority seems to be for low down. That is wrong. Usually it is high up; obstruction high up is much more likely to give rise to an increase of indican than obstruction low down; it is due, also, to many causes where there is no obstruction at all. I don't think the estimation of indican would be likely to help us much in this case. Some writers have laid stress on it, but I don't think the majority have found it of any use in diagnosis.

Practically one can't go farther in this case without laparotomy. It was done in this case, and a very small tight cancerous stricture was found, not much bigger than a signet ring, in the region of the hepatic fixture. The hernia was practically reduced and did not count.

Given these facts, what is the prognosis? S.—That would depend upon whether there were secondaries or not. Dr.—Where would you look for them? S.—In the retro-peritoneal region. Dr.—Certainly. What else would it depend on? S.—The extent of the growth. Dr.—Anything else? S.—The condition of the patient. Dr.—What else? S.—The length of time. Dr.—Yes, every day makes the prognosis worse. But there is another element,—who does the operation. That is one of the personal elements we cannot eliminate in a case like this. If it is done by a man of experience it is of greater value than if done by a greenhorn. We have recently published in Boston some stomach statistics of operations gathered from 150 cases, and one is appalled at the mortality. The average was about four cases to an operator. Everybody was getting his experience on those cases,

and consequently there was a very high mortality. On the next 150 cases in Boston, it won't be so high. So the things to be considered are the general condition of the patient, the length of time, the presence or absence of metastases, the man who does the operation, and, of course, the after treatment and nursing. We have nothing especial to say about the treatment in this case other than surgical. The medical treatment of intestinal obstruction is not a subject that one is inclined to dwell on with pride.

191 Marlboro St.

THE DIFFERENTIAL DIAGNOSIS AND TREATMENT OF THE CHRONIC NON-TUBERCULAR JOINT DISEASES.*

WILLIAM E. BLODGETT, M. D.,
Detroit, Mich.

The object of this paper is to offer for your consideration a simple outline of the results thus far of the work of Dr. Joel E. Goldthwait and his associates in Boston on the general subject of chronic non-tubercular joint diseases. These results are based on careful clinical and laboratory study of a very large number of cases, many of the cases being followed for a number of years, and cover the group of joint diseases confusedly called chronic rheumatism, gouty rheumatism, arthritis deformans, gout, rheumatoid arthritis, and a variety of other names. The continued study of these indiscriminate cases leads to classification of them into (1) Simple Villous Arthritis, (2) Atrophic Arthritis, (3) Hypertrophic Arthritis, (4) Infectious Arthritis, and (5) Chronic Gout.

The classification does not provide for certain rare chronic joint disorders, as, for instance the neuropathic joint lesions in tabes, commonly known as Charcot's joints, or for traumatic derangements of joints, or for joint disturbances due to adjacent neoplasm, or for other articular disturbances which are not dependent on any disease, primary or secondary, of the joint itself. Thus, to illustrate, the knee may be permanently flexed owing to muscle contractures dependent on infantile paralysis, but the restriction of mobility could not properly be referred to a disease of the knee itself. It may, moreover, become necessary to add to the classification in order to provide for types of joint disease not yet recognized. But with the limitations given above, and excluding, of course, the large group of tubercular arthritis, indiscriminate cases of chronic joint trouble as they present themselves for treatment naturally fall under one or another of the five types: (1) simple villous arthritis, (2) atrophic arthritis, (3) hypertrophic arthritis, (4) infectous arthritis, (5) chronic gout.

As in any group of conditions that are similar to each other, as, for instance, in the group of acute abdominal lesions, so in the group of chronic non-tubercular diseases, immediate diagnosis is not infrequently impossible; furthermore, in rare instances, the same patient may show evidence of two types of joint disease, though in such cases the onset of one type is usually found clearly to have preceded that of the other, so that the patient himself has recognized the two types as distinct; but, while it is not possible entirely to disprove all connection between the

*Read before the Wayne County Medical Society, Feb. 28, 1905.

several types, their continued distinctness in clinical course, total pathological complex, and response to treatment appear to indicate that they represent separate diseases.

Simple Villous Arthritis. This type is variously called chronic synovitis, or hyperæmic, relaxed, or dry joint.

It may arise from any cause that induces a congestion of the synovial membrane, as trauma, general loss of tone, or interference with the return circulation. The inducing trauma may be single from without, or constantly repeated from within, as in the faulty weight-bearing and constantly repeated strain that results from flat or pronated foot, or from such corpulence as, in order to maintain upright equilibrium, requires standing with the knees slightly flexed. This type of joint trouble is met with also after parturition when there has been no suspicion of puerperal infection, dependent apparently on general reduction of tissue and vascular tone.

The synovial membrane, for one or another of these causes starting to become congested, cannot spread at its margins on account of its attachments, or laterally outward on account of the fibrous capsule; it must therefore, as it swells, fold inward into the joint cavity, thus forming villi and fringes. These fringes are rubbed over each other in the movement of the joint, or may be squeezed between the articulating bones; irritation and congestion are thus increased, and large pedunculated tabs may be developed, which, on account of deficient blood supply, are liable to undergo fatty degeneration, with production of intra-articular lipomata—the so-called lipoma arborescens. Microscopically such a fringe is likely to show a pedicle carrying vessels that are undergoing obliterative endarteritis; a peripheral endothelial layer continuous with that of the synovial membrane, overlying a fibrous mesh filled with small round cells that represent the product of the chronic inflammation; and an interior showing the lipomatous metamorphosis. Rarely the fringe is subject to metaplasia into cartilage or bone. Fringes getting free from the synovial membrane form loose bodies in the joint—joint mice. The same general development of intra-articular villi is likely to result from any chronic arthritis, including the tubercular form; but, in the type under consideration, simple villous arthritis, the fringe formation is not a manifestation of a general disease, but represents a purely local process, and is unaccompanied by any considerable alteration of cartilage or bone.

The symptoms and treatment of simple villous arthritis are largely implied by its aetiology and pathology. The process is most commonly found in the knee, and, being dependent on the formation of villi, naturally results symptomatically in swelling and tenderness of the synovial membrane, crepitation and pain on motion, and a tendency to mechanical limitation of mobility. Muscle spasm, strong adhesions, and actual locking of the joint so that it cannot be fully extended, as seen in cases of dislocation of a semilunar fibro-cartilage, are not to be expected. The joint fluid is normal, or, if there be great irritation, excessive. The villi may often be palpated on either side of the patella as soft masses, and seen by radiography beneath the

patella. If the process has gone on to lipomatous formation, the lipoma may not infrequent be felt as a more or less distinct body on one or the other side, and slightly above, the patella. When the patient stands, the normal fossae on on either side of the patella are likely to be obliterated. The process does not naturally extend to the other joints, bone and cartilage are practically unaltered, and there is no constitutional reaction.

In treatment, any joint strain, as from pronated foot, pendulous abdomen, or excessive or abnormal use, which we have seen are aetiologic, should as far as possible be eliminated. The joint should be steadied, its motion limited, and its circulation supported, as by a snug flannel bandage which serves all these purposes. Local stimulation without increase of irritation is indicated, as by alternate hot and cold douches, and, if the general circulation is deficient, it would seem reasonable to treat this factor as well. This sort of treatment may be expected to avail for the early stages of the process; if, in the more advanced or obstinate cases, such non-operative measures, which it would seem conservative and wise always to try first, fail to relieve, and if the symptoms warrant it, the joint should be opened under the most perfect asepsis, and the offending villi removed. A large series of such operative interference has proved satisfactory and effective.

Atrophic Arthritis. Atrophic arthritis has been called also rheumatoid arthritis, and is undoubtedly identical with the arthritis chronica ankylopoetica of Janseen and other German observers. Dr. Goldthwait has given to it the name of atrophic arthritis because the essential feature of the process is atrophy.

The aetiology is unknown.

Pathologically the disease consists of a beginning villous synovial process, soon succeeded by fibrillation and disintegration of the articular cartilages, and progressive atrophy of cartilage and bone, so that the whole length of the bones adjacent to affected joints becomes osteoporotic; in the last stage, cancellated bone grows through the former joint, so that a true synostosis results in the deformed position.

This type of joint disease is slowly progressive, and, unless arrested, involves practically all the joints, and is a frequent cause of complete disability and residence in our alms-houses. The proximal phalangeal joints of the fingers are usually early attacked, and present at first spindle-shaped swellings with the overlying skin white and often moist with cold perspiration, succeeded soon by contractures and an annular constriction around the middle of the joint. This constriction is a manifestation of the atrophy of the cartilages, which is shown also by radiography. Other affected joints present similar signs, subject to alteration dependent upon the location of the particular joint. The spine is usually spared in the early part of the disease. The process is attended during acute exacerbations by pain even when the joint is at rest, and is subject to recrudescence and remission. The course may cover many years. The subject is usually a woman, young or old, and, as the disease progresses, becomes emaciated and pale, although the blood shows no changes except a tendency to increase of red corpuscles. The lymphatic nodes are not enlarged. The urine shows nothing important.

As the essential feature of this type is atrophy, the appropriate principle

of treatment is thorough stimulation local and general—locally by such means as hydrotherapy, faradism, hot air, massage, mechanical vibration, and encouragement of use. Pain is combated by immobilization for a few days, if necessary, and small doses of the salicylates or allied compounds for a few days only. While in many cases the salicylates will prove of much value in subduing the pain, it is to be remembered that any of the drugs allied to salicylic acid are more or less depressing and disordering to digestion, and that a prolonged use of these drugs, therefore, especially in this condition that calls for forced nutrition, is distinctly contraindicated. Large doses, moreover, are to be avoided, for, if the drug in a given case is to have any effect at all, five grains two to four times per day will be usually as effective as more. The drug is at best simply analgesic—in no way specific. After using the drug two or three days, a simple alkali, such as phosphate of sodium, or potassium or sodium bicarbonate, or any other, with copious ingestion of water, will usually suffice. The eliminative organs in general should be kept active. Contractures and adhesions should be overcome by manipulation under an anaesthetic, with due regard to the bone atrophy and the produced liability to fracture. A marked villous condition indicates incision. The general treatment is the same as for incipient pulmonary tuberculosis, although this type of joint disease bears no known relation to tuberculosis of any kind—forced feeding on a general mixed diet, in which meat, red or white, forms an indispensable part, fresh air, and general roborant measures.

Hypertrophic Arthritis. Hypertrophic arthritis has been called indiscriminately arthritis deformans, gout, or gouty rheumatism. As its name implies, the essential features of this process is hypertrophy of bone and cartilage.

The specific aetiology is unknown, but excessive use, trauma, advanced age, and exposure to damp and cold are factors. It occurs more commonly in the male sex and the latter half of life, but is not confined to this sex or to this period.

The process consists of thickening of the articular cartilages at their edges, with formation of ridges or nodes, and metaplasia of these ridges and nodes into bone, thus mechanically interfering with joint mobility. The bone hypertrophy is both palpable and demonstrable with the Roentgen rays. The central parts of the cartilages, subjected to special pressure, are absorbed, and the bone underneath becomes sclerosed or "eburnated." The joint, however, is never obliterated, as is the case in atrophic arthritis, interference with motion is mechanical, and marked deformities do not result.

The symptoms depend on mechanical interference with motion, and on pressure irritation of neighboring nerves, producing referred pain. Occuring in the fingers, the process leads to the well-known Heberden's nodes; these nodes involve the terminal finger joints, in contradistinction from the lesions of atrophic arthritis which occur in the proximal finger joints, and, unlike the deposits in chronic gout, are composed of hard bone and are attached to the phalanges. In the spine, the process leads to stiffness, commonly in the lower half, usually more marked in one lateral flexion than in the other, without kyphosis, and causes referred pain due to nerve-root pres-

sure. In this way, hypertrophic arthritis of the spine is a frequent cause of obstinate sciatica and intercostal neuralgia—apparently the commonest cause. In the hip, the same process leads to the morbus coxae senilis, the commonest disease of the hip in old people. In the knee, palpable ridges are formed, and in the foot, painful bony spicules may result. Blood and urine show no noteworthy changes. The process is not naturally progressive, and under appropriate treatment subsides with apparently a smoothing over and perhaps partial absorption of the bony outgrowth.

The principle of treatment appropriate to this condition of hypertrophy and mechanical irritation naturally is local rest and protection, applied according to the part affected. Thus sciatic pain due to this process in the lower spine is usually quickly relieved by a low plaster jacket, followed in due time by a less irksome form of protection, such as a leather jacket, or a low canvas jacket reinforced by steels. In the acute stage, operative removal of the new-formed bone appears only to stimulate the hypertrophy; on the other hand, when the process is thoroughly quiescent, and especially when the bone formation is the response directly to trauma or excessive use in a single joint, and is thus not indicative of any special constitutional tendency, removal of an hypertrophy may restore full mobility to a joint. Forcible manipulation, to increase mobility or to correct deformity, is of course in this disease to be avoided. General treatment appears to have no influence, except as the general health is kept up, and the excretive organs regulated. The diet need not be forced, and may include the ordinary amount of meat.

Infectious Arthritis. Infectious arthritis includes most of the cases of so-called chronic rheumatism, as, in fact, probably also acute rheumatism. It is identical with the polyarthritis in children known as Still's disease.

The disease depends either on micro-organisms within the joints or on toxins formed outside. Apparently any of the infectious organisms may be causative, as the pneumococcus, the staphylococcus, the streptococcus, the gonococcus, the influenza bacillus, or the dysentery organisms. Possibly toxins from the tubercle bacillus may cause mild joint symptoms, which, of course, would be entirely distinct from the arthritis produced by actual joint or epiphyseal invasion by the tubercle bacillus itself; but more likely the joint symptoms accompanying pulmonary tuberculosis are due to toxins from the superadded organisms common in the pulmonary disease. Joint involvement, even in so-called acute rheumatism, will often be found to follow some extra-articular lesion, that may be thought too mild to be important; the introductory symptoms arising from such a lesion have formerly been considered prodromata of the joint disease, but are too varied to be thus regarded, and indeed often occur without the joint symptoms appearing at all. The original lesion it seems reasonable to regard as the nidus of infection, to which the joint involvement is secondary. The frequent severity of the joint involvement out of all proportion to the original focus of infection may be compared to the severe axillary adenitis secondary to a forgotten pinprick of the finger. This secondary relation of infectious arthritis to the primary focus explains in part why so many diseases, such as tonsillitis, chorea, endocarditis, pericarditis, meningitis, pleurisy, neuritis,

and peritonitis, have been attributed to rheumatism; apparently there is a causal relation between rheumatism and these diseases, and it may be conjectured that, in certain instances, the joints, after harboring the infection, send it out to other organs, thus becoming an intermediate cause; but usually the arthritis, instead of being the cause, is an effect of the disease in question, or an effect of an original focus of infection from which arises also the disease in question as well as the rheumatism. The intestinal tract, the torsils, and the genito-urinary system appear to be prolific sources of the primary infection. The rheumatism is tonsillitic, and not the tonsillitis rheumatic.

The pathology, as also symptoms, varies with the kind and virulence of the exciting micro-organisms, and according or not as the organism itself is in the joint, varying all the way from fleeting joint symptoms to acute joint abscess. In the exposed joint, as of the fingers, the process is first manifested by spindle-shaped swelling, due to increase of synovial fluid, as in atrophic athritis, but either the swelling subsides in a few days, or else, when the organism itself is within the joint, the periarticular structures begin to become infiltrated, and swelling persists due to this cause and not to fluid. The pneumococcus, the streptococcus, and the typhoid bacillus may produce destruction of bone; the gonococcus, on the other hand, tends to extensive infiltration of the periarticular soft tissues. If bone changes take place in infectious arthritis, the destruction and subsequent reformation extend, as shown by radiography, widely outside the edges of the cartilages, as in a septic periostitis, thus distinguishing infectious arthritis from the atrophy of atrophic arthritis or the hypertrophy of hypertrophic arthritis.

Infectious arthritis may be monarticular or, as more usual, polyarticular. If many joints are attacked, the attack is severe usually only in one or two of the joints, where the organisms themselves probably have got a foothold. All the joints that are to be attacked show a tendency to be attacked at nearly the same time, infectious arthritis being thus unlike the gradual progression of atrophic arthritis. Contractures and adhesions leading to ankylosis are frequent, unless the process is mild or is arrested. The blood shows an initial leucocytosis, followed by a secondary anaemia. The urine is characteristic simply of a septicaemia. The lymphatic nodes are enlarged.

Locally the treatment, during the acute stage, is protection, as by pillow and straps, splint, or plaster Paris cast, and hot, soothing applications. Later, local stimulation and correction of deformity or adhesions, if such exist. A fulminantly septic joint demands, of course, prompt incision, irrigation, and drainage. If, in a joint that is not acute enough to require immediate operation,—and very few are acute enough for this—improvement at the end of three or four weeks is not marked, incision and irrigation are indicated to forestall extensive infiltration of the capsule and produced injury to joint function. The incisions are made on either side of an elbow or knee, the joint thoroughly flushed with hot salt solution or a suitable antiseptic, and the incisions entirely closed except for a few strands of silk allowed to remain a day or two. In the advanced stage of the process, when the capsule is already infiltrated and thickened, and villous formation is decided, and

the joint bound by adhesions and adaptive changes of the soft structures, the condition may be more or less improved by forcible manipulation, or by excision of fringes, according to indications. The general treatment of this type of arthritis is directed against the original or a contributory focus, if discovered and found still active, and against the toxaemia or septicaemia. The possibility of involvement of organs other than the joints, as the endocardium or pericardium, should of course be had in mind. As referred to above, salicylates may be of great service in controlling the initial pain, but, in view of their depressive effect, should not be given in large doses or continued more than a few days. Free elimination by bowels, kidneys, and skin should be induced. A simple alkali with large ingestion of water will overcome any tendency to the concentration and hyperacidity of urine that accompanies a great variety of diseases, and is a result and not the cause.

Chronic Gout. Chronic gout is apparently a type of arthritis much less common in this part of the country, and there has been less opportunity to study it.

Aetiology is unknown.

The process consists of deposition of sodium urate in the soft periarticular structures, softening and discharge of these deposits, and absorption of bone, shaft or end, adjacent to deposits, as shown by radiography. Although commonly found about the distal phalangeal joints of the fingers, where the hypertrophic Heberden's nodes also are found, these true gout deposits, in distinction from the hypertrophic nodes, are soft and, being free from the bone, are movable.

For local treatment, rest and heat are indicated during acute exacerbations. As far as general treatment is understood, it is directed towards stimulating the eliminative organs, especially the kidneys. Colchicum and salicylates appear to be useful temporarily for combating attacks of pain. During remissions, tonic and nutrient treatment is given, and a plain, non-alcoholic diet with a due proportion of nitrogenous food is allowed. Even in severe cases, marked restoration of function may be accomplished.

Two considerations come to mind in reviewing as a whole the results of the work of Dr. Goldthwait and his co-workers. The first is the natural question why, if these types of chronic non-tubercular joint trouble represent really distinct diseases,—why have not pathologists long ago recognized them. The answer is that there is practically not a single pathological change—disregarding its extent and distribution—in any one of these types which may not be simulated in some of the others. Tuberculosis presents an almost unique fine pathology, that identifies it; but the villous formation of simple villous arthritis may occur in any chronic arthritis; bone hypertrophy, the characteristic feature of hypertrophic arthritis, is found in the late stage of atrophic and infectious arthritis; and cartilage atrophy, characteristic of atrophic arthritis, is found, due to pressure, also in hypertrophic arthritis. Furthermore, post-mortem material, until recently almost the only source of information for the pathologist, usually represents only the end results in the joints, and throws no light on the pathological development. The discrimination into the five types depends not on any peculiar tissue changes, but on a comparison of clinical course, physical signs, radio-

graphic evidence, response to treatment, bacterial contents, and total pathological complex and development as judged by operative as well as post-mortem findings. The basis for discrimination, therefore, is not simple, but compound.

The second consideration is that discrimination of type is necessary for intelligent treatment. Our knowledge of the various types of chronic non-tubercular joint diseases will doubtless be increased and refined, and treatment made correspondingly more precise. But a necessary condition for increase of knowledge and for application of appropriate principles of treatment to the individual case is discrimination of types.

312 *Washington Arcade.*

CLINICAL REPORTS

Pulsating Exopthalmos with Successful Ligation of Carotid.

MAX BALLIN, M. D.
Detroit, Mich.

Mrs. F., 42 years old, saloonkeeper's wife, was referred to me on Dec. 1, 1902. She gave the following history:—Patient was struck, in July, by her drunken husband, on the left side of the head. The blow was quite hard, patient staggered for a moment, but did not lose consciousness, nor did she vomit. Shortly after this accident Mrs. F. noticed a swelling and reddening of the left eyelids and a very peculiar noise in her head. This noise intermitting in character became louder and louder, the left eye-ball commenced protruding, the left eye-lids were greatly swollen and reddened, and the power of vision in the left eye became diminishd. The right eye also appeared inflamed, but not as much as the left one. The noise in the head was pulsating in character and kept patient from sleeping; it was so loud that her husband sleeping next to her often heard it during the night. She had consulted an eye specialist, who just made application on the swollen eye, then believing that he had to deal with a subconjunctival abscess, he had incised the conjunctiva, without relieving the very troublesome symptom. On closer study the ophthalmologist came to the conclusion that he had to deal with a case of pulsating exophthalmos and referred the patient to me for treatment; viz., for ligature of the common carotid artery.

The family history of the patient did not show anything in regard to this trouble. Of the personal history, free use of alcohol was admitted. Syphilis denied. On examination on the same date, I found the following:—Tall, strong woman—left eye-lids greatly swollen and of purple color. Between them the left eye-ball is protruding, so that it projects very far from the lids. The veins of eye-lids very much dilated. The conjunctiva is greatly chemotic and cornea swollen and somewhat hazy. On inner side of the swollen conjunctiva a small fresh scar from the recent incision. The finger put on the eye-lid feels a pulsating movement of eye-ball, just like the apex-beat over the heart. This pulsating movement of the eye-ball could also be clearly seen. Synchronic with this pulsation one heard a pulsating noise, of a blowing whistling character, to be compared to a very exaggerated murmur over a leaking heart-valve. This noise could be easily heard, with a stethoscope, eight inches from the patient's eye. I could hear it all over the skull and also on the neck over the left carotid triangle. The noise was synchronous with the pulsation of the carotids. Compression of the left carotid

*Reported at the Detroit Ophthalmological Club.

stopped the noise and also caused the eye-balls to fall back a little. By compression of the left eye-lids and eye-ball, the eye-ball could be pressed back, only to immediately pulsate forward again. Mobility of the eye-ball was slightly reddened and swollen, but there was neither exophthalmos to any amount nor pulsation. Vision of left eye was lessened considerably, pupils reacted. The tension of left eye-ball seemed increased; there was pulsation of the retinal veins.

Examination of internal organs, heart, lungs and urine, did not show anything pathological. The bloodvessels seemed to be soft without arteriosclerotic changes.

I was convinced that I had a very rare case before me, a case of pulsating exophthalmos and that ligature of the left common carotid artery was indicated.

On Dec. 2, 1902, I performed this operation under chloroform narcosis. I ligated the common carotid artery below the omo-hyoid muscle, with a double strong catgut thread. I did not divide the artery but pulled my threads very tight, and also crushed the vessel with the hemostatic forceps, between the two ligatures, in order to injure the intima and secure impermeability of the vessel. The pulsation of the eye-ball and the intracephalic noise stopped immediately with the applying of the ligature. Patient made an uneventful recovery. I had trouble to keep her in bed even for a few days. The exophthalmos disappeared, the swelling of the lids and conjunctiva was greatly lessened, within a very few days. But there was still some slight redness six months after operation, when I saw the patient the last time. The noise has never returned since the operation and patient did not mind the slight reddish appearance of her left eye.

Park Building.

Complete Inversion and Prolapse of the Uterus.

J. A. MacMILLAN, M. D.,
Detroit, Mich.

Mrs. H. M., aet 27, at full term of 5th pregnancy was sent to the Woman's Hospital for delivery. Labor pains began at 4 a. m., Jan. 1st, 1905, and continued till 9 p. m. of the same day. At this time dilation was complete, the uterine contractions were feeble, and there had been no progress for several hours. The head presented R. O. A., and delivery was affected in a few minutes with forceps, very little traction being used. Attempts were made by the hand grasping the fundus uteri to cause expulsion of the placenta, but while there were some contractions, still they were not affectual and after twenty minutes some traction was made upon the cord. The uterus was easily palpated, and was well down in the pelvis. About half an hour after the delivery of the child the placenta was expelled and immediately after it came the completely inverted uterus. The patient complained of considerable pain but there were no signs of shock. The inverted uterus was dark red, and venous blood oozed profusely from all parts of it.

With the left hand pressing firmly where the fundus is normally palpated, steady pressure was made with the other hand on the most dependant part. The whole mass was thus forced into the vagina, and by continued pressure with fingers and thumb the fundus was restored to its normal relations. The patient made an uninterrupted recovery.

The patient had always been frail, and was subject to occasional faint-

ing spells. This was her third delivery at full term. In all her confinements there seemed to be lack of uterine force and forceps were used.

In 1902 she contracted syphilis, the initial sore being on the lip, and she had taken mercurials for nearly two years. The patient's general condition and the lack of tone in the uterine muscle were predisposing causes of the inversion of the uterus. The traction on the cord while not great, was the direct etiologic factor.

666 Woodward Ave.

TRANSACTIONS OF SOCIETIES

DETROIT ACADEMY OF MEDICINE.

MARCH 14.

"The Comparative Value of Some of the Newer Methods of Treatment in Skin Diseases." H. R. Varney, M. D.

MARCH 28.

"Anatomy of the Lymphatic System." F. B. Tibbals, M. D.

"Composition, Origin and Function of the Lymph and the Factors Controlling Its Flow. Max Ballin, M. D.

"Application of Our Knowledge of the Lymphatic System." W. F. Metcalf, M. D.

APRIL 10.

"The Radical Mastoid Operation." Ray Connor, M. D.

HARRISON D. JENKS, M. D., Secretary.

WAYNE COUNTY MEDICAL SOCIETY.

MARCH 6.

"The Physiological Action of Water From the Hydro-Therapeutic Standpoint." Tobias Siegel, M. D.

Discussion. Hiram A. Wright, M. D.; Jean Vernier, M. D.

MARCH 13.

"Strain As a Factor in Cardio-Vascular Lesions." H. B. Anderson, M. D., Toronto. Clinical Professor of Medicine, University of Toronto. This paper will be published in the JOURNAL.

Discussion. Chas. G. Jennings, M. D.; Geo. E. McKean, M. D.

MARCH 20.

Intermittent Claudication. Report of two cases. J. Flinterman, M. D.

Discussion. A. W. Imrie, M. D.; A. W. Ives, M. D.

MARCH 27.

Ventrofixation. Frank E. Pilcher, M. D.

"Trauma and Shock as Factors in the Production of Mental and Nervous Derangements." Samuel Bell, M. D.

Discussion. Dr. Delos Parker; Dr. David Inglis.

APRIL 3.

"On the Development and Morphology of the Uriniferous Tubules of Certain Animals." With stereopticon illustration. Dr. G. Carl Huber, Ann Arbor.

Discussion. W. C. Martin, M. D.; Howard Baker, M. D.

APRIL 10.

"Comparisons of Gross and Microscopical Lesions of the Kidney, with Special Reference to Nephritis." Dr. R. S. Rowland.

"Interpretation of the Various Pathological Lesions of the Kidney in Terms of Signs and Symptoms." Dr. H. S. Olney.

Discussion. P. M. Hickey, M. D.; H. E. Safford, M. D.

APRIL 17.

Symposium on Uremia:

Etiology. Dr. Gilbert J. Anderson.

Symptoms and Diagnosis. Dr. M. V. Meddaugh.

Treatment. Dr. W. J. Wilson, Jr.

Discussion. E. G. Knill, M. D.; F. Carrow, M. D.

Report of a Case of Diabetes Insipidus. Dr. M. A. Fechheimer .

APRIL 24.

"Diagnosis in Surgical Affections of the Kidney." Dr. W. F. Metcalf.

Discussion. W. P. Manton, M. D.; H. O. Walker, M. D.

"Patient Operated for Kidney Abscess." Dr. F. J. W. Maguire.

L. J. HIRSCHMAN, Chairman Program Com.

DETROIT MEDICAL JOURNAL

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The Records of the Medical Service of the Japanese Army.

The records of the Japanese in the present war with Russia are truly remarkable in many ways. The complete annihilation of Russia's Pacific naval squadron, largely by means of torpedo boats, mines, and long-distance guns, was notable. The practical application of modern inventions to the use of the army has seemed most remarkable; a telephone behind each firing-line, practicable war-balloons, the wonderful mechanical contrivances used in the siege of Port Arthur, all are of the keenest interest to the modern world. But after all is said of their wonderful military feats, by far their greatest achievement is a medical one.

The Japanese are the first to show official appreciation of an army medical corps. The primitive idea of an army surgeon was the camp follower whose primary work was to dress the wounds of those injured in battle. And in spite of the advances and claims of preventive medicine, military authorities in general have not gotten far away from that idea. The consequence was, and is, that the most important work of an army medical corps, that of protecting the men from disease, has received very little recognition. After a man has a bullet-wound or a broken leg, or becomes delirious with fever, the surgeon has something to say; but in the selection of a camp-site, source of water supply, choice of food, efficient prevision of medical supplies, medical advice is more usually scorned than followed.

The result has been, that war forces since the Crusades have had the same experiences in greater or less degree, of losing from four to forty times as many men by preventable disease as by actual wounds and necessities of war. So recently as 1894, the French military expedition to Madagascar lost 29 men killed in action and over 7,000 died en route from preventable diseases. In our own Santiago campaign in 1898, bullets and wounds killed 268, while 3,862 died of disease. The British suffered still more severely than this from typhoid fever in their South African campaign.

Gen. Nogi reports that with his army of 100,000 men engaged in the siege of Port Arthur from May to December 1st, there were just 40 deaths from disease. There were 24,642 names put on the sick-list, so the mortality was one-sixth of one per cent. In the Spanish-American war, lasting about half this time, it is stated that 70 per cent. of the men whose

names were put on the sick-list, died. Add to this the fact that the Japanese were in a foreign country, while the greater part of the American army never left its native shore, and the contrast is still more striking, although it must be said that so far as climatic differences were concerned, the Americans probably underwent the greater change.

In Japan itself the showing has been still better. One hospital ship made seven trips and carried 2,406 wounded back to Japan without a death. In the Reserve Hospital at Hiroshima 9,862 had been received up to August first, and only 34 had died. In Tokyo, 1,105 wounded had been received into the hospitals, and up to July 1st, not one had died.

This is a remarkable record. It did not happen accidentally. Observers on the scene state that it is the result of the practical application of the principles of preventive medicine, learned by the Japanese in European and American medical schools. They know no more about these things than we do. They have simply given modern medical science a chance to show what it could do, and *Gott sei dank,* the men to whom the opportunity came were willing and able. The medical history of this war, if reports are correct, will be one of the most important chapters ever written in the advancement of hygiene.

But, after all, the greatest result is the encouragement to the medical optimist. Here is a definite proof on a large scale that disease can be prevented and that the precautions taught by preventive medicine are worth while. Here is incentive to renew the fight against preventable disease, a glimpse of actual results which here may only come to our children's children, but which our efforts may hasten. It seems likely now that Japan is a hundred years ahead of us in the practical application of military hygiene —we hope it is not more than that!

"Every death from preventable disease is an insult to the intelligence of the age." Even the laity are beginning to realize this and they will more and more hold the medical profession responsible for not insisting with greater vigor and firmness, on the execution of those laws which modern medical science has demonstrated to be necessary for the protection of human life. When you are asked for proof of what the execution of these laws can do, you need only to refer to the mortality record of the Japanese army.

Appendicitis and Progress.

In pondering on the advances made in medical and surgical knowledge during the past five decades, one's mind immediately and naturally reverts to appendicitis as the best example of a disease, the study of which has meant the saving of many thousands of lives. In this connection, diphtheria and yellow fever equally hold our attention; yet the advances in the knowledge of these affections are not as widely realized and understood as are the immense strides in our knowledge of appendicitis.

Our lay brothers, understanding but little of the magnificent progress which science is making, are wont to ask: "Is appendicitis a new disease?" or "Why did not our grandfathers have it?" or again, "It is just a fad, isn't it?" and even some of the older men in the profession have failed to realize

the frequency and hence the importance of what they too, sometimes term "a fad."

Inflammation of the appendix has always been the most important acute abdominal affection. So varied are its phases and so important is a thorough understand of them, that, like pneumonia, appendicitis should be discussed, at least yearly, in every medical society in the land. While the wisdom of the general practitioner undertaking the operation of appendectomy may be questioned, no one can assert that the consideration of the disease should be left to the surgeon alone. The early recognition of appendicitis has saved thousands of lives, and when the profession thoroughly awakens to the necessity of this, followed by prompt operation, the deaths will be still further reduced, for despite the immense literature on the subject, there are some, either too dense to grasp its meaning or too stubborn to admit that they, in the past, have been groping in the dark. Early diagnosis and immediate operation, have been harped upon, until the phrases have become almost trite; yet, judging from sentiments which one repeatedly hears expressed, there are those who hearing, hear not.

Two works, devoted exclusively to appendicitis have for some time been announced, one by Deaver of Philadelphia, and the other by Kelly of Baltimore. The latter, which has just appeared, is one of the finest monographs in medical literature. A review of it will be found in the current issue.

Benjamin R. Schenck.

Clinical Reports.

With this number we begin the publication of a department of Clinical Reports. It is designed to furnish a permanent record of rare or interesting cases. It is from the multiplication of these records of single cases that monographs are compiled and general professional knowledge is advanced. Every practitioner of medicine should consider it his duty as well as his privilege to add to the sum total of professional knowledge by making a permanent record of cases that are really unusual.

It is not designed to publish in this department articles on diseases—merely the actual facts observed in a given case, with all the evidence to support the diagnosis given, and collated facts in the history of the case or examination of the patient. Our readers are cordially invited to make use of our columns for such purpose.

Hospitals for Small Cities.

The requirements of the modern treatment of disease are such that many cases can be infinitely better managed in hospitals than in private houses. This, of course, applies very largely to surgery, and its importance in many kinds of medical cases is being more and more appreciated. Typhoid fever, for example, can be treated in a hospital with much more comfort to the patient and much less risk and inconvenience to the family than in the ordinary private house. Every city of ten thousand or more inhabitants should have such an institution, however small.

In this connection the account on another page of the new Hackley Hospital in Muskegon is of interest. These small hospitals are peculiarly appropriate institutions for erection by private charity as memorials for

distinguished or honored dead or for other reasons. Physicians can often influence the disposal of money in wills and should not forget it. Not every city can have a Hackley for its benefactor, but that should not be a discouragement, for much good can be done with less than he gave.

Only a few days ago an honored citizen of Flint, Mr. James J. Hurley, died and left to that city twelve acres of land and $25,000 as a nucleus for building a hospital. It is to be hoped that other men of wealth in the state will see fit to leave property for the same purpose. It is difficult to imagine a gift more certain to do good to a man's fellow creatures than such as this.

Dr. Ochsner, the well-known surgeon of Chicago, was awarded a prize at the St. Louis Exposition for his exhibit of plans of a model hospital for small cities. These plans are given in the *Clinical Review* for January, 1905, in connection with which Dr. Ochsner also discusses the changing of a residence into a hospital—the usual occurrence in 90 per cent. of our small cities. One important thing to bear in mind is the provision of a site of generous dimensions. If the twelve acres given at Flint are a suitable location for a hospital, not one foot of the ground should be sold.

Detroit Postgraduate School.

The fourth announcement of special courses given by the Detroit Postgraduate School of Medicine has just appeared in a very attractive style. The course has been greatly extended, and a number of additions have been made to the Clinical Faculty. The course will extend from May 8th until June 4th, a period of four weeks, and a very extensive schedule has been outlined. Detroit is making great progress as a medical center, and the School is especially fortunate in securing Harper Hospital for its clinical work. A very important addition has been made by the offering of Optional Courses in Intubation and Tracheotomy by Dr. B. R. Shurly; Operative Surgery, Dr. F. B. Walker; Operative Gynecology, Dr. B. R. Schenck; Pathology, Dr. P. M. Hickey; Radiography, Dr. P. M. Hickey; Hygiene and Public Health, Dr. Guy L. Kiefer and Dr. E. H. Hayward; Stomach and Intestines (Special Advanced Work), Dr. C. D. Aaron.

EDITORIAL NOTES

Dr. Benjamin Brodie is spending the season in Japan.

Dr. A. O. Parrisot is the Republican nominee for mayor of Mt. Clemens.

Dr. Abrams, of Dollar Bay, has opened an office also in Hancock, Michigan.

Dr. Mary E. Green, Jr., of Charlotte, was married on Feb. 22nd to Mr. Francis Fiske, of St. Louis.

Dr. G. H. Lynch, for the last year with Dr. A. W. Crane, of Kalamazoo, has moved to Traverse City, and will take up the practice of the late Dr. H. B. Anderson.

Pennsylvania is to establish two state sanitoria for the treatment of incipient pulmonary tuberculosis, and the legislature has just appropriated $300,000 for that purpose.

Dr. C. G. Jennings of this city has been appointed a member of the American national committee for the International Medical Congress which meets in Lisbon in April, 1906.

Among the politicians who "landed" in the recent elections were Dr. Walter H. Sawyer, of Hillsdale, as regent of the state university, and Dr. Victor Sisung, mayor of Monroe.

The second course of Herter lectures at the Johns Hopkins Medical School

will be delivered next October by Dr. Hans Meyer, professor of pharmacology in the University of Vienna.

The Physicians Defense Co. of Indiana, has been refused permission to operate in the State of Ohio, owing to failure to comply with the laws regulating such corporations in that state.

The New Hospital for contagious diseases in Montreal will be called the Alexandra Hospital. It will have nine separate buildings, each entirely isolated and with its own nursing staff.

President Roosevelt delivered the address at the graduating exercises of the Naval Medical School in Washington, on March 25th, and presented the twenty-three graduates with their diplomas.

Dr. C. G. Darling has been made Clinical Professor of Surgery in the medical department of the University of Michigan, and Dr. C. B. Nancrede has had added to his title, Director of Surgical Clinics.

The Michigan members of the committee tendering a dinner to Dr. Osler at the Waldorf, New York, on May 2nd, are Dr. V. C. Vaughn and Dr. George Dock, of Ann Arbor, and Dr. Chas. G. Jennings, of Detroit.

The State of Indiana has recently appropriated $130,000 for the establishment of an institution for the care of epileptics. It will be conducted on the cottage plan similar to the New York institution at Sonyea.

Governor Pennypacker of Pennsylvania has vetoed a bill for the prevention of idiocy by a surgical operation on the ground that it is not humane. The bill provided that under certain conditions, congenital idiots should be castrated.

An edict by the czar has been enacted since the birth of his son, to the effect that the families of physicians are entitled to a pension when the physician succumbed to infection acquired while in the public service fighting the epidemic.

Dr. F. T. Wilson, who has just completed three years' service as surgeon with the United States army in the Philippine Islands, has returned with his family to Owosso, Mich., after a short visit with his father, David Wilson, and family, West London.

A Chinese Hospital has been established in Vancouver. It was built and is financed and managed entirely by Chinese citizens. It is said to be well fitted with modern appliances, but decorated and partly finished in Oriental fashion. The physicians will be regularly qualified practitioners .

The Republicans and Democrats of Pontiac line up in the annual spring contest with a doctor at the head of each ticket. In the absence of any more exciting issue the contest will be one between the "strenuous life" and the "simple life." Dr. H. C. Guillot, Republican, held the office for three strenuous terms, but was defeated last election by Dr. J. D. Riker, who is now completing an uneventful term and has been nominated again.

The trustees of the Johns Hopkins university on April 3rd elected Dr. Llewellyn Franklin Barker, now head of the department of anatomy in the University of Chicago, and in Rush Medical college, to the professorship of medicine made vacant by the resignation of Dr. William Osler. At the same time Dr. Willis Sydney Thayer, associate professor of medicine in Johns Hopkins, was elected professor of clinical medicine. The latter professorship is one of new creation.

Dr. Barker is a native of Canada and was born in 1887. He has held the positions successively of Assistant Physician, Fellow in Pathology, and Associate Professor of Anatomy in the Johns Hopkins Medical School. Since 1900 he has been Professor of Anatomy in Chicago University and was recently made Associate Professor of Clinical Medicine there.

Dr. Frank W. Shumway of Williamston has been appointed secretary of the Michigan State Board of Health, to succeed Dr. H. B. Baker. He began his new duties on March 29.

Dr. Shumway is 47 years old. He was born on Christmas day, 1857, in Lowell, Kent county. His father, Dr. Charles Shumway, was for years a practitioner in Kent, whither he came from New York.

Dr. Charles Shumway died when his son was five years old. The family moved to Lansing, where the boy was educated in the common and high schools, and then followed his native appetite for medicine by commencing study in the office of the late Dr. Charles Hayden. He stayed there two years, after which he went to the Cleveland Medical college, because it was his father's Alma Mater.

In 1881 he graduated, and came to Williamston, Ingham county, where he was a successful practitioner. He was local health officer for 10 years, experiencing many epidemics. He lived the life of the doctor in the country districts, out at all hours, in all weathers, horseback, in carriage, or afoot. His fellow townsmen

all regard him as a fine physician. He is an excellent nurse and his close attention to each patient gave him the only attacks of illness he has ever had. He nearly died of diphtheria in 1882, and was in danger of death from pneumonia in 1904.

He was appointed to the pardon board by Governor Pingree in 1899. He was reappointed by Governor Bliss, and on the reduction of the board to three members was given the presidency and the long term. He has shown administrative ability, and is personally urbane, approachable and likeable.

False Sympathy.

Countryman (to dentist)—"The tooth next to that 'un aches, too, Doc."
Dentist—"Yes, it aches in sympathy."
Countryman—"Yank it out. Durn such sympathy."

RECENT DEATHS.

John W. Kirtland, M. D., University of Illinois, 1886, died at his home in Lakeview, Mich., March 13th, aged 66.

Casper L. Nauman, M. D., Medical College of Ohio, Cincinnati, 1876, died at his home at West Branch, Mich., on March 3rd, from cirrhosis of the liver.

Dr. G. A. Doren, who has been superintendent of the Ohio asylum for the feeble-minded at Columbus for 46 years, died last month. He was a Democrat, but held his place through all administrations because of his unusual fitness for the position.

Dr. E. A. Chaffers, well known west side physician, died at his home, 530 Twenty-third street, on March 21st., after a short attack of pneumonia. Dr. Chaffers, who was 42 years old when he died, came to Detroit from Montreal about ten years ago and shortly afterwards married Miss Kittie Berghoefer, of this city. He is survived by the widow and three daughters—Patrica, aged 8; O'-Leary, age 4, and Yonne, aged 3 years. Dr. Chaffers was a graduate of McGill university.

Dr. Theodore C. Dolan died at St. Mary's hospital March 22nd. He was 25 years of age and graduated from the Detroit College of Medicine in 1904. After receiving his diploma he went to Lima, O., where he started in practice, but in six weeks his health broke down and he was obliged to return to Detroit. Some weeks ago he entered St. Mary's hospital, suffering from tuberculosis of the kidneys. He was an enthusiastic student and made an excellent record in college. His home was in Windsor, where his parents and brothers and sisters survive him. The body was taken to Windsor for burial.

ANTI-TUBERCULOSIS SOCIETY.

On Tuesday, March 14th, Dr. S. A. Knopf, of New York, addressed a public meeting in the Y. W. C. A. building, on Tuberculosis. The meeting was under the auspices of the committee of the State Medical Society to Petition the Legislature for the Establishment of a Tuberculosis Sanitorium. Dr. H. J. Hartz presented Mr. Samuel T. Douglas, as presiding officer, and Dr. G. L. Kiefer, City Health Officer, made a short preliminary address, setting forth the purpose of the meeting and stating very forcibly the need of public interest in the tuberculosis problem.

Dr. Knopf's address was of a popular nature, reiterating in an interesting manner the well-known facts about tuberculosis and urging his audience to assist in the work of ridding the state of Michigan of this pest.

At the close of the meeting many cards were signed for membership in an Anti-Tuberculosis League, and a meeting for permanent organization will soon be held.

This is a definite move for a campaign in which every physician should be enlisted. It was organized and is being carried on by physicians and is doing work in which we may all be proud to have a share.

Dr. Knopf, after leaving here, made three addresses in Battle Creek, spoke before the legislature in Lansing, and lectured also in Saginaw, before leaving the state.

CORRESPONDENCE.

To the Editor:

In the March Detroit Medical Journal we note Dr. Spohn's paper on Erysipelas.

I have found his treatments unsatisfactory. The ichthyol should be painted on pure over and one inch beyond red margin. Washed off and reapplied every 12 hours. His calomel will sweep out, but not scour out. His guiacol is too

expensive. Emptying bowels with calomel and sodium phosphate, we render the canal quite clean by 10 grains of mixed sulpho-carbolates every two hours. Sodium salycilate, 10 grains, two hourly, may be added.

Pilocarpine hydrychlorate ,1 1-20 grain.

Strychnine arsenate, 1 1-50 grain.

Every two hours until pronounced effects, is almost specific, but applicable only toasthenic cases. Nuclein will help, pure icthyol internally will assist, cure will be prompt.

In Merck's Archives Dr. Storck states that "If drugs continue to disturb the stomach they are worse than useless." This is an assertion too sweeping. It would compel us to exclude all emetics from practice. It would cater to that anti-medicine idiosyncrasy of some nervous people until a dose of bromides, iodides, salines or a drink of hot water would be considered bad. Reckless statements like these throw physicians and regular practice into disrepute. Perhaps they are sometimes made to advertise a palatable proprietary product. They should not pass unquestioned for they are not true. There are limits at which we should stop the use of stomach irritating medicine. As well might it be said that a mode of treatment causing pain is more harmful than helpful at all times.. It is my practice to give sodium phosphate ½ to 1 drachm per hour for about 24 hours after being called to a case of typhoid fever for the first time. This treatment causes vomiting quickly in some cases, slowly or not at all in others, but I observe that the patients that are quick to vomit when drinking sodium phosphate make the easiest recovery from this fever. If the patient has courage I force the use of the sodium phosphate until vomiting and purging are almost constant and the duration of such a case is always brief. No matter what non-emetic medicine it may be, if chemically pure it is, if properly diluted, less nauseating than if it is a commercial article. The sulphocarbolates will illustrate this thought.

—C. E. BOYNTON, M. D.

Los Banos, Calif.

PROGRESS OF MEDICAL SCIENCE

Triplets in Uterus Bicornus.

Frank (Muenchener Med. Woch., Feb. 21, 1905), reports a case of triplets in a uterus bicornus unicollis. The child in the right side of the uterus was the largest, born last, and born dead. Of the two on the left side, one lived a half hour, and the other ten days only. The mother recovered. The author has failed to find another similar case on record.

The Museum in Medical Teaching.

Maude E. Abbott, Montreal (Journal A. M. A., March 25), notices the great advance in laboratory methods in medical teaching, but considers that the adaptation of the medical museum to the didactic method of teaching is too little understood. When properly systematized the museum furnishes most valuable object lessons far more instructive than mere reading—a sort of observational study enabling the student more easily to fix the facts in his mind. She describes at length the methods employed in McGill University, the classification and general arrangement and the use of the specimens for direct teaching purposes in the way of examinations and quizzes on the specimens presented.

Note on Use of Dionin.

Hood (Am. Jour. of Ophth., Feb., '05), discussing the value of the new therapeutical agent Dionin, in eye diseases, says the drug does not produce local or superficial anæsthesia but is rather to be classed as a deep analgesic, of particular use in inflammation of the iris and ciliary regions where atropine fails, or as an aid to the action of atropine. He uses a 5 per cent solution, one instillation every twenty-four hours. He gives Roder's summary which coincides with his own observations.

1. It is an analgesic of no little power.
2. Enhances the action of atropine.
3. Powerful vaso dilator and lymphagogue action upon the eye.
4. Promotes absorption of exudations, deposits in the pupillary space, and of post operative debris after cataract extraction.

5. Helps clear up corneal opacities in some cases of interstitial keratitis.
6. Without effect in all other forms of corneal opacity.
7. Influence on the glaucoma process as yet unsettled.

—DON M. CAMPBELL, M. D.

Resection of Nasal Septum.

Kilian (Archives fur Laryngologie—Band 16 F 3), reports his modifications of the Kreig-Bonninghausen-Freer and Mensel method of sub-mucous window resection of the nasal septum. His essential features in method are the single short incision through which both mucous layers can be elevated and separated, one from the other, by the use of his special long specula. Ease and accuracy in each case are claimed. Thorough aseptic technique is required. The local anæsthesia is produced by sub-mucous injections of two centimeters of a half per cent cocaine solution and four drops of adrenalin, 1-1000. 20 per cent solution cocaine is applied externally to the mucous membrane prior to injection.

The anterior wedge-like piece of the vomer is removed by Kilian's bayonet like chisel, the operator guiding it with one hand, keeps the nose open with the speculum in the other hand, while an assistant uses the mallet. The remaining deviated septa is resected with Hardman's forceps. Vioform is insufflated into the cavity between the layers of mucous membrane. Great stress is laid on perfect approximation of the flaps, and these are held in place by sutures, if necessary. They are also held by loosely applied tampons. These are usually two in number on a side and allowed to remain for two days. Kilian performs this operation on an average in twenty minutes.—B. R. SHURLY, M. D.

The Prognosis of Epilepsy.

William A. Turner (Boston Medical and Surgical Journal, Feb. 16, '05).

Before the bromide treatment of epilepsy was practiced (1857) different writers gave percentages of cures varying from 5 to 10 per cent. Since then estimates have varied between 5 and 12 per cent. These divergences are explained by the fact that formerly men were not so precise in diagnosis, and were not agreed on the definition of a cure.

The prospect of cure is to be considered in conjunction with the patient's sex, hereditary history, age of onset, duration of disease, frequency, character and time of seizures. It is observed that male subjects show a larger percentage of arrests, but are more liable to concomitant mental impairment. "A family tendency to either epilepsy or insanity, though offering no obstacle to the arrest of seizures in favorable cases, materially increases the likelihood of the disease becoming confirmed and the supervention of dementia." "Epilepsy commencing in infancy and childhood is the least favorable for the arrest of the fits, and the most favorable for the confirmed disease. The common type of epilepsy, or that commencing during puberty, is the most favorable form, both as regards the arrest of the seizures and the absence of mental infirmity. Adult epilepsy is unfavorable, but senile epilepsy is tractable." As for duration, early cases are decidedly the most responsive to treatment. Remarkable exceptions occur, but "on the whole there is a progressive tendency for epilepsy to become confirmed the longer the disease lasts without definite treatment," and a similar tendency toward enfeebled mind. The frequency of attacks has a marked effect both in producing obstinate resistance to arrest and pronounced mental impairment. Attacks occurring only a few times a year are often curable, but those occurring several times daily are hopeless. The cases of grand mal respond more readily to treatment than the petit mal, and psychic deterioration is less frequent, but when it does ensue it is usually more serious. Combined grand and petit mal cause the most profound dementia.

Remissions in epilepsy are common and are of such long duration that a cure cannot be claimed unless there has been freedom from attacks for nine years. Long remissions are favorable to cure. The writer reports 10 per cent of cures in a series of 147 cases.

Cerebro-Spinal Meningitis.

In a symposium on this subject in the Alabany Med. Annals., March, '05, are discussed (a)—the pathology and bacteriology, by W. T. Councilman; (b)—the symptoms and diagnosis, by H. L. Elshner; (c)—the treatment, by C. G. Stockton.

(a) All cases of meningitis are cerebro-spinal, and probably all involve the encephalon superficially; the avenues of infection are by the blood, the lymphatics,

and by direct extension. The epidemic form of the disease is caused by the diplococcus intracellularis meningitidis of Weichselbaum, and is less fatal than the forms produced by the pneumococcus or streptococcus. The cases examined have shown purulent invasion from the meninges into the vicinity of the blood vessels in the brain substance, sometimes with the presence of bacteria, and an increase of cortical neuroglia. The three micro-organisms mentioned furnish the great majority of acute meningitic infections, and in about equal proportion as observed by the writer. Primary meningitis is, with rare exceptions, the result of the bacillus of Weichselbaum. Pneumococcus invasion is usually secondary,—as a sequel to acute otitis media, mastoiditis, sinusitis, pneumonia, or endocarditis. Streptoccic infection is secondary to the same conditions and also to severe traumata. In the meningitis due to the two latter organisms there is an acute proliferative inflammation of the veins and arteries, which is not found in the epidemic form. In most other respects the different infections resemble each other in their pathologic manifestations.

(b) The symptoms of meningitis vary with the form it assumes and the severity of the individual case. Opisthotonos is a very constant phenomenon; headache is intense and persistent; general hyperæsthesia is usual, as is photophobia and insomnia; the facies and the position in bed are characteristic; the reflexes are often abnormal, but do not vary in any constant manner; the pulse is rapid, increasingly so toward death; temperature is elevated, with hyperpyrexia sometimes in fulminant cases; abdomen is retracted, constipation common, albuminuria usual; the skin often shows herpes, erythema, roseola, or hemorrhage; convulsions may occur in children, but rarely in adults; vomiting accompanies those cases with long prodromal periods; polynuclear leucocytosis is the rule; metastatic joint lesions occasionally supervene; Kernig's sign is almost always present, but one must guard against considering it pathognomomic. Lumbar puncture is a useful adjunct to diagnosis and should always be employed; one ought not, however, to rely on the macroscopic appearance of the fluid, but insist on microscopical and bacterial tests, which will usually determine definitely the variety of infection, and often be of importance in indicating proper prophylactic measures. The diagnosis of meningitis complicating pneumonia is practically impossible without lumbar puncture, and the differentiation from typhoid with cerebral symptoms is made by the same means, together with the usual tests for typhoid... . ..It should also be remembered that the latest researches seem to prove the occasional occurence of a purulent meningitis due to the bacillus typhosus alone.

(c) In treatment, it is important that every case should first be isolated. Anfrecht's method of giving hot baths (104 degrees F.) has given favorable results in many hands; lumbar puncture has numerous advocates, and it has been supplemented by sub-arachnoid instillations of lysol solution; subcutaneous injections of corrosive sublimate have been practiced with benefit; still honored is the treatment with opium, as also with bromides, antipyrine, ergot, and mercury. The writer concludes from personal experience that a judicious selection and combination of the hot baths, lumbar puncture, antipyrine, laxative mercurials, and other means to maintain the eliminative functions, will bring about the best results,—not neglecting the very important regulation of hygienic surroundings.

—CHAS. S. OAKMAN.

NEW INSTRUMENTS AND DEVICES

Mention of new instruments and devices in this department is entirely complimentary and articles illustrated are judged on their merits.

We invite manufacturers and physicians to send us matter suitable for publication under this head. A description of the device and an electrotype or half-tone with a base not greater than two and five-eighths inches should be sent.

Always mention the price of the article in question.

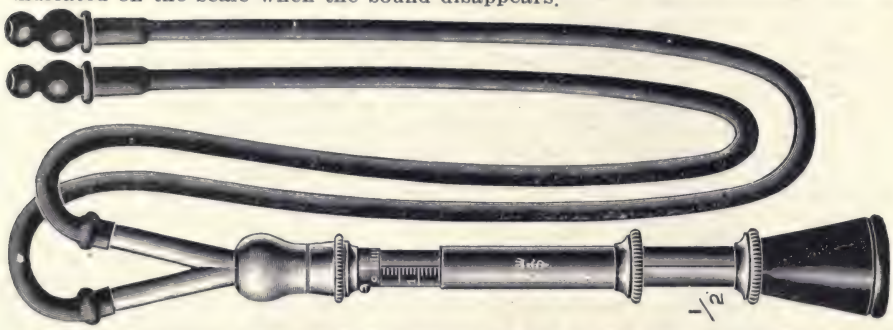
The management cannot undertake to return cuts unless postage for same accompany the letter with which they are sent.

To Our Readers—The Detroit Medical Journal publishes descriptions of such aids to the profession as it knows to be reliable and trustworthy. We shall be pleased to furnish information as to the articles mentioned, or the articles themselves, upon receipt of an inquiry.

Oertel's Stethoscope.

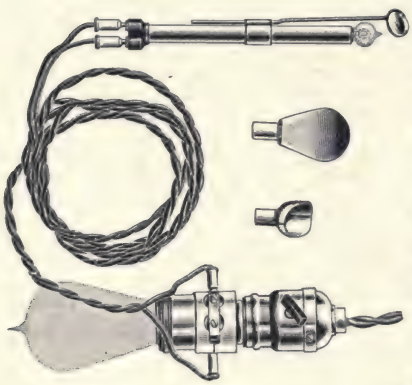
This instrument is a clever mechanical aid and instrument of precision in diagnosis which promises to be of great permanent value. It can be used as an ordinary stethoscope. In addition to this, the intensity of sounds may be accurately measured by it. This is obtained by changing the size of the aperture in the tube. Three movable concentric metallic tubes are used, provided with

a scale. By changing the position of these tubes, one can enlarge or decrease the opening at will. The strength of the sound over a given valve of the heart, or other locality, is indicated by the size of the opening in the instrument which is indicated on the scale when the sound disappears.



Bock, of Munich, has reported at some length on the use of this instrument (Berlin Klin. Woch., Nov. 23, 1900), and has fixed upon a scale of 40 for the mitral sound in healthy adults, 18 for the pulmonary, and 20 for the aortic sound. The absolute value of sounds could, however, be of little service because of variations in the thickness of the chest-wall, and other conditions which will readily occur to one. The true value of the results of the use of the instrument lies entirely in the relative value of the various sounds. This, for example, would offer a precise method of determining whether or not the pulmonic second sound was really accentuated or not. Price, $6.50.

Illuminating Outfit.

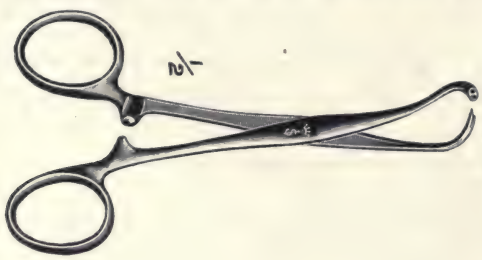


The inspection of cavities of the body by means of electric light introduced directly has proved an extremely useful diagnostic aid. The instruments offered heretofore, however, have been usually quite expensive, complicated, and often so bulky, as to restrict their use to office work.

The apparatus illustrated may be attached to any electric light lamp-socket, either direct or alternating current, and is so light as to be easily carried about. The large lamp acts as a rheostat, adapting the current to the requirements of the small lamp. A shield for rectal and vaginal work, a throat mirror and sleeve, and a tongue depressor are included in the outfit, which sells for $5.00 packed in a neat box.

New Tenaculum Forceps.

This instrument was modified by Dr. O. C. Smith, of Hartford, Conn., after a style used by Colin in Paris. It has two diverging teeth on the upper jaw and a flat ovoid platform with two perforations on the under jaw. It has also a slight curve allowing it to lie close to the body.

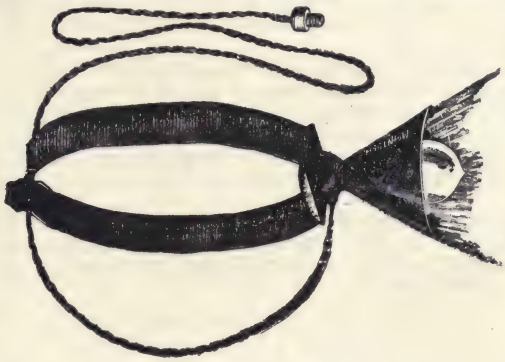


The advantages claimed for these forceps are (1) the avoidance of crushing the tissue. They are meant to grasp and hold the margins of delicate tissues, as the peritoneum, pleura, bladder, stomach, etc. This forcep makes two harmless minute punctures (2). The

lower jaw of this forcep being blunt, can be carried to the bottom of an abdominal incision. (3). The slight curve helps to keep the instrument out of the operator's way. (4). It holds the margin of any tissue securely, not tearing out with considerable traction. Price, $1.50.

New Head Lamp.

This instrument, like the previous one, is meant to be used on a commercial lighting current, and can be screwed into a lamp socket. Price, $3.50.



BOOK REVIEWS

Golden Rule Series: 14 volumes. Bristol, England: John Wright & Co.

1. **Surgical Practice.** By E. Harry Fenwick, Surgeon to London Hospital. 78 pp. 8th Edition.
2. **Gynecology.** By S. Jervois Aarons, M. D.—Soho. 75 pp. 4th Edition.
3. **Obstetric Practice.** By W. E. Fothergill, M. A., M. D., Manchester. 77 pp.
4. **Medical Practice.** By Arthur Henry Evans, M. D., London. 77 pp. 5th Edition.
5. **Psychiatry.** By Jas. Shaw, M .D., London. 74 pp. 2nd Edition.
6. **Physiology.** By J. W. Hall, M. B., and J. Ackworth Menzie, M. D., Oivens College. 80 pp. 2nd Edition.
7. **Ophthalmic Practice.** By Gustavus Hartridge, F. R. C. S., Westminster. 69 pp. 2nd Edition
8. **Skin Practice.** By David Walsh, M. D., London. 106 pp. 2nd Edition.
9. **Aural and Nassal Practice.** By Philip R. W. de Sauti. 81 pp.
10. **Hygiene.** By F. J. Waldo. 69 pp.
11. **Infants and Children.** By George Carpenter, London. 167 pp. 2nd Edition, enlarged.
12. **Refraction.** By E. E. Maddox, M. D., Edinburg. 86 pp.
13. **Dental Surgery** By Chas. W. Glassington. 69 pp.
14. **Anaesthesia.** By R. J. Probyn-Williams, M. D., London. 67 pp.

These little volumes contain aphorisms concerning the practice of particular branches of medicine, and they are by no means uninteresting volumes. Their popularity in England is shown by the fact that one of them at least has passed through eight editions.

The style of the contents may be judged from the following from the volume on surgery:

"Never try fluctuation across a limb, always along it."

"Do not forget that your incision should radiate:—

1. In abscesses pointing near the nipple.
2. In abscesses near the anus.

3. In scarifying chemosis of the conjunctiva. And that your incisions should be longitudinal:—

1. In the hand.
2. In the perineum.
3. On the vertex."

A Text-Book of Alkaloidal Therapeutics By W. F. Waugh, M. D., and W. C Abbott, M. D., Chicago; The Clinic Publishing Co., 1904.

The mission of this book is thus stated in the preface; "to get together from all sources all the facts obtainable concerning the alkaloids and active principles, and to present them in a ready-to-use form." This was an interesting and worthy task. It is somewhat of a pity that the authors could not resist temptation and be content with carrying out that mission. Instead, however, hey have begun the consideration of each drug by naming the preparations of it which are offered for sale by the drug house with which the authors' names are now always connected. Not content with this they have included in the list of subjects treated many drugs not alkaloids at all, and whose only claim to representation here is that they are sold by this same drug-house. What picric acid, potassium permanganate, zinc oxide, iodoform, and croton oil, with many others, have to do with alkaloids is not explained.

There is a great deal of information in the book; also a great deal which we feel sure is misleading. If these remedies were as efficacious as one is here led to believe, disease would be ever short-lived and the practice of midicine would be indeed "one glad sweet song."

Medical Diagnosis. By Austin W. Hollis, M. D. Lea Bros & Co. 1905.

This is one of the Medical Epitome Series, edited by Dr. V. C. Pedersen, and intended by the publishers to "embrace the entire realm of medicine" in books that are essentially manuals. Such volumes find a large sphere of usefulness, but they should be regarded as mere introductions or adjuvants to larger works. The author's aim is to offer "accuracy, clearness, and completeness to date, with due sense of relative importance of the various subjects." This aim has been approximated, and to those whose needs indicate such a volume, it is recommendable. We may doubt whether it is wise to present diagnosis in separate books; the interdependence of medical (so-called) and clinical diagnosis is so indissoluble, that their dissociation invites prejudice to one or the other. In "Medical Diagnosis" —all chemical, bacteriological, and microscopical procedures are barely alluded to. The invalauble aid of radiography in certain diseases is not mentioned. The book is well arranged and well set up. It sells for one dollar.

A Text-book of the Practice of Medicine... For Students and Practitioners. By Hobart Amory Hare, M. D., B. Sc. Author of A Text-Book of Practical Therapeutics; A Text-Book of Practical Diagnosis, etc. In one volume of 1120 pages, with 129 engravings and 10 full-page plates in colors and monochrome. Cloth, $5.00, net; leather, $6.00, net; half morocco, $6.50, net. Lea Brothers & Co., Philadelphia and New York, 1905.

This handsome volume of over 1100 pages is Prof. Hare's most pretentious book. His Diagnosis and Practical Therapeutics have proven to be such satisfactory volumes that one expects much from the author in his larger work. This expectation the new volume from his pen eminently justifies. Written in a clear and direct style which has made his other books popular, this volume shows also that careful elimination of the unimportant and cumbersome mass of details which so easily beset many of our authors, with the result of cheapening their work.

The author has seen fit to include some description of many little known diseases, upon the ground that with our new national interests in the tropics, physicians must be prepared to recognize and treat tropical diseases when they are brought home to us. So this resumè names 54 infectious diseases. So do our troubles multiply! Kola-azar and Kubisagari and many other names unfamiliar in the temperate zone are here met, and we believe the author is correct in his

view that a brief account of these diseases should be included in every student's training.

The author has made a few inevitable omissions; he has not mentioned the X-ray treatment of Leukemia; he has failed to mention the parathyroids in Graves' disease and Myxoedema. He has done a service in calling attention to the use of the agglutonometer in the diagnosis of typhoid, but we believe he is mistaken in intimating that his test is as delicate as the microscopic Widal. In Germany, where it has been longest in use, no such claim is made for it. The chapter on Ascites is very unsatisfactory, while that on Diabetes Mellitus is particularly good.

As would be expected, the chapters on treatment are very satisfactory and the volume is to be highly commended for that feature alone.

That illustrations can be used to good advantage in a text-book on medicine is certainly proved here. They can and do add greatly to the interest and value of the text. While the pictures of vaccination are poor from the students' point of view, because they do not show a typical normally developing vaccination, those on variola, typhoid ulcer, and malarial parasites are particularly good.

In conclusion it may be said that this volume surpasses in value any similar publication for many years back and the author, publishers and the profession are all to be congratulated on its appearance.

Medical and Surgical Report of St. Luke's Hospital, Chicago. 1904.

In addition to the usual statistics of work done in the year, this report contains the reports of the following interesting cases:

1. Congenital Stenosis of Oesophagus and Duodenum-Syphilis Neonatorum. T. C. Dagg.
2. General Tuberculosis in an Infant. Henry B. Favill.
3. Severe Hemorrhage From Stomach in Typhoid Fever. Edward B. Hutchinson.
4. Actinomycosis: Clinical, Pathological, and Bacterial Reports. L. L. McArthur and J. C. Hollister.
5. Extirpation of Gasserian Ganglion for Facial Neuralgia with Report of Seven Cases. A. E. Halsted.

These cases were well studied and the accounts are in several instances illustrated, making the report a publication of permanent value.

The Vermiform Appendix and its Diseases, by Howard A. Kelly, A. B., M. D., Professor of Gynecology in The Johns Hopkins University and Elizabeth Hurdon, M. D., Assistant in Gynecology in The John Hopkins University. Octavo, 827 pages, with 399 original illustrations, some in colors, and 3 Lithographic plates. Philadelphia, W. B. Saunders & Co., 1905. Cloth, $10; half morocco, $11 net.

The appearance of Kelly's work on the Vermiform Appendix and its Diseases has been eagerly awaited by all who are familiar (and who is not?) with the author's Operative Gynecology. The latter, on account of its lucid text and magnificent illustrations, marked an epoch in medical publication. Until the present book was issued, the work was unsurpassed by anything in America or abroad, but it must now be relegated to second place, for this new volume is even more complete and more beautifully illustrated than its predecessor. It surpasses one's expectations; indeed, it is difficult to imagine a more perfect monograph on a subject, the importance of which, both to the general practitioner and to the specialist, is second to none in the whole field of medicine and surgery.

Our space does not permit of a review as complete as we would like or as the book deserves. It must be read and the the illustrations studied to be appreciated.

The first 50 pages review the history of the subject. These chapters are most interesting and entertaining. One hundred and forty pages deal with the embryology and anatomy of the appendix. The embryology is based upon the study of 54 human embryos. It is all first hand work and is in itself a most complete and valuable monograph. The comparative anatomy, the anatomy of the peritoneal folds and fossæ, the various positions and congenital anomalies of the appendix, its histology, the progressive and retrogressive changes which it undergoes and many other phases are thoroughly covered. Especially to be noted are the illustrations of the reconstructions of the blood and lymphatic supply.

The study of the diseases of the appendix begins at page 195. The general pathology and bacteriology are first given, 160 pages being devoted to them. The histories and the illustrations are mostly from the author's own cases and specimens. The next 150 pages deal with the clinical side of the subject and most of

the remainder of the book with the surgical treatment. The descriptions and illustrations of the various methods of doing appendectomy are the best ever published. One can follow the various steps as clearly as though demonstrated on the cadaver.

Special sections deal with appendicitis in children and during pregnancy, the relations of the appendix to gynecologic affections, hernia of the appendix and the medico-legal aspects of appendicitis.

One must see and study the illustrations in order to appreciate their clearness and beauty. Not only is their execution superb but their selection is beyond criticism. For the practitioner, who does an occasional appendix operation, the work is invaluable; to the surgeon and gynecologist, no matter what his opportunities and experience have been, it will prove instructive as well as a source of much pleasure.

The author, the artists, the publisher, and we might add, the American profession, are all to be congratulated on this splendid addition to medical literature.

B. R. S.

RECEIVED:

(Grateful acknowledgement of the receipt of the following is hereby made. Further notice in our review column may be given).

Program of the Eighth Annual Meeting of the American Gastro-Enterological Association, New York, April 24-25, 1905. Chas. D. Aaron, M. D., Detroit, Secretary.

Studies in the Psychology of Sex. Vol. IV.: Sexual Selection in Man. By Havelock Ellis, Philadelphia; F. A. Davis Co.

Diseases of the Skin. By H. Radcliffe-Crocker, M. D., F. R. C. P., Physician for Diseases of Skin in University College Hospital, London, etc. In two large volumes; third edition; illustrated. Philadelphia: P. Blakiston's Sons & Co, 1905.

The Development of the Human Body. A Manual of Human Embryology. By J. Playfair McMurrich, A. M., Ph. D., Professor of Anatomy in the University of Michigan. Second edition; illustrated. Philadelphia. P. Blakiston's Son & Co., 1904.

Analysis of One Thousand Cases of Static Foot Trouble. By W. E. Blodgett, M. D., Detroit. Reprint.

A Report of a Case of Caries of Part of the Temporal Bone, with a Deep Abscess of the Neck. By Emil Amberg, M. D., Detroit. Reprint.

The Necessity of the Co-Operation of the Dental and Medical Professions in Abating the Adenoid Evil. By Emil Amberg, M. D., Detroit. Reprint.

41st Annual Report of Harper Hospital, Detroit. J. L. Hudson, President of Board of Trustees.

Prosthetic Surgery. By F. B. Tiffany, A. M., M. D., Kansas City. Reprint.

Stamina. By A. N. Bell, A. M., M. D., New York. Reprint.

The International Medical Annual. 1905. E. B. Treat & Co., N. Y.

Gynecology. By Henry J. Garrigues, A. M., M. D. J. B. Lippincott Co., Philadelphia.

Practical Pediatrics. A Manual of the Medical and Surgical Diseases of Infancy and Childhood. By Dr. E. Graetzer, editor of the "Centralblatt fur Kinderheilkunde" and the "Excerpta Medica." Authorized translation, with numerous Additions and Notes, by Herman B. Sheffield, M. D., Instructor in Diseases of Children, and Attending Pediatrist (O. P. D.). New York Post-Graduate Medical School and Hospital. F. A. Davis Company, Philadelphia.

Eye, Ear, Nose, and Throat Nursing. By A. Edward Davis, A. M., M. D., Professor of Diseases of the Eye in the New York Post-Graduate Medical School and Hospital, and Beaman Douglass, M.D., Professor of Diseases of the nose and Throat in the New York Post-Graduate Medical School and Hospital. F. A. Davis Company, Philadelphia.

Conservative Gynecology and Electro-Therapeutics... A Practical Treatise on the Diseases of Women and Their Treatment by Electricity. By G. Betton Massey, M. D., Attending Surgeon to the American Oncologic Hospital, Philadelphia. F. A. Davis Company, Philadelphia.

Progressive Medicine. Issue of March 1, 1905. Lea Bros. & Co., Philadelphia.

Practical Medicine Year Books... Vol. 1—General Medicine by Billings and Salisbury. Vol. ii—General Surgery by J. B. Murphy. The Year-Book Publishers, Chicago.

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A Case for Fine Discrimination.

The selection of suitable apparatus for treating affections of the ear, nose, throat and lungs is a matter that demands the careful consideration of every practicing physician, because of the great prevalence and seriousness of this class of cases. Nebulization has come to play a very important part in this branch of therapeutics, and rightly so, as it is based on the correct principle of applying suitable medicaments directly to the parts involved.

There are various styles and makes of Nebulizers on the market. They all have certain features in common, but some of them have distinctive features of their own which require a nice discrimination when selecting an outfit of that kind.

We will not presume to mention any particular make of Nebulizer, but will refer our readers to a little pamphlet entitled "Nebulization and Allied Methods," from which valuable suggestions can be obtained. This pamphlet can be had from the Globe Manufacturing Co., of Battle Creek, Mich.

Respiratory Tract: Affection, Symptoms, and Treatment.

By Dr. ARTHUR B. SMITH, Springfield, O.

The arevage physician is frequently vexed in finding a condition which resists his best efforts to bring about a cure. This holds good in almost every disease at some time or other, but particularly in affections of the respiratory tract, where there may be a great variety of symptoms in several cases of the same disease.

Almost every physician has some favorite prescription for coughs, bronchitis, laryngitis, etc., which he uses until suddenly it seems to lose its efficacy—why, no one knows. Then another remedy takes its place until it, too, fails to give the desired result. It is rarely that one finds a cough remedy which will be consistently good in the majority of cases. Theoretically there appears to be a well-founded objection to the use of cough syrups in general, but nevertheless there are times when nothing else gives satisfaction; therefore, the physician pins his faith to that remedy from which he and his patients derive the most good. It is not always easy to find such a remedy, but when it is once found, it is equally difficult to dispense with, and often the physician is almost compelled to resort to a routine treatment. In such cases, of course, he wants the best.

There are constantly being placed on the market new formulas for affections of the air passages. Some of these formulas are of undoubted benefit in some cases, but usually it will be found that the results are far from satisfactory. Many of them cannot be taken when there is any gastric complication, as is sometimes the case, because of consequent nausea and vomiting. Others seem almost invariably to act as cardiac depressants and are highly objectionable for that reason. With the advent of heroin, however, these disagreeable features have, to a great extent, been avoided. Heroin, in the vast majority of cases, can be tolerated by even the most sensitive stomach, and, if any disturbance should occur, it can easily be obviated by decreasing the dosage and then gradually resuming the previous amount. Heroin can be prescribed, in cases which are complicated by an enfeebled heart, without danger of depressing effects. As compared with codeine, its sedative action on the respiration is much more powerful. The fatal dose of heroin is said to be one hundred times the efficacious dose, while with codeine the efficacious dose is one-tenth of the fatal dose. In other words, heroine is ten times safer than codeine, and can be given in much larger doses, if necessary, without danger. It appears to exert a specific action on the center of respiration without causing disturbances of any other organs or centers, and there is no danger of acquiring any habit by its use.

In phthisical patients the well known lack of appetite and intolerance of various foods render it imperative to give remedies which will not in any way interfere with the digestive functions, while at the same time controlling or alleviating the cough and other distressing conditions.

Some time ago my attention was called to a preparation composed of a solution of heroin in glycerine, combined with expectorants, called Glyco-Heroin (Smith). Each teaspoonful of this preparation contains one-sixteenth grain of heroin by accurate dosage. It is of agreeable flavor, therefore easy to administer to children, for whom the dose can be easily reduced with any liquid, or by actual measurement. It possesses many advantages not shown by any other preparation I have used, and has none of their disagreeable features.

In citing some of the cases treated with this remedy I shall not go into a minute description of any case, but briefly state the conditions which existed and the results obtained, which were uniformly good.

Case 1. S. B., aged 16. Caught a severe cold while traveling. This developed into an unusually severe attack of bronchitis with mucous rales, pain cough and some slight fever. Prescribed Glyco-Heroin (Smith) one teaspoonful every two hours, decreased to every three hours. After a few doses were taken there was a decided improvement, the respirations were slower and deeper, the expectoration freer and the temperature normal. In a few days the patient was practically well and able to return to school. No medicine except Glyco-Heroin (Smith) was given and the results from its use were excellent.

Case 2. W. L., aged 31. Acute bronchitis. Painful cough, with difficult expectoration, particularly when in a reclining posture. Glyco-Heroin (Smith) in tea spoonful doses, every three hours, gave speedy relief and a cure was effected in a few days.

Case 3. S. W., aged 60. Chronic bronchitis. Had coughed for years, with expectoration of a thick, yellow purulent and very offensive matter. Had lost flesh gradually until about twenty pounds below usual weight. No appetite, very constipated, pains all over chest, night sweats and insomnia. Patient on the verge of nervous prostration and greatly weakened. She was given bromides, a tonic, and Glyco-Heroin (Smith), the latter in the usual dose at intervals of two hours. The first few doses were not well borne, as they seemed to cause some nausea, but by giving a smaller dose and then gradually increasing it, tolerance was soon obtained, and the results were remarkable. The cough and expectoration greatly decreased, the appetite improved and the patient became much better in every way. The treatment was continued as before, except that the Glyco-Heroin (Smith) was given every three hours. In three weeks the patient was eating almost everything she pleased, and sleeping well. The night sweats had stopped, together with the cough, and, as the

patient expressed it, she "felt like another woman." At present she is in perfect health and needs no medicine except an occasional laxitive.

Case 4. B. E., aged 26. Severe bronchitis accompanying an attack of influenza. Various remedies were tried in this case, with negative results, until Glyco-Heroin (Smith) was given in teaspoonful doses every three hours. In a short time decided relief was obtained and the cough stopped permanently.

Case 5. R. L., aged 6. Capillary bronchitis with pains over chest, cough and difficult expectoration. Glyco-Heroin (Smith) administered 15 drops every three hours. After taking a few doses the condition was much improved, and a speedy return to perfect health followed.

Case 6. W. H., aged 5. Whooping cough. Spasmodic paroxysms of coughing, sometimes being so severe as to cause vomiting. Tenacious mucus was present, requiring great expulsive effort to loosen it. There was little fever, but the patient was much prostrated and weakened by the cough. Glyco-Heroin (Smith) was given in 10 drop doses every two hours with good results. This was combined with hygienic treatment, the patient being given as much fresh air as possible. In a few days the condition was much ameliorated, the cough under fair control, expectoration was freer and easier to raise, and convalescence uneventful. The case was discharged cured and there were no unpleasant sequelae, the patient at present being in perfect health.

Comment on Antikamnia & Heroin Tablets.

Under the head of "Therapeutics," the Medical Examiner, contains the following by Walter M. Fleming, A. M., M. D.* regarding this valuable combination: "Its effect on the respiratory organs is not at all depressing, but primarily it is stimulating, which is promptly followed by a quietude which is invigorating and bracing, instead of depressing and followed by lassitude. It is not inclined to affect the bowels by producing constipation, which is one of the prominent effects of an opiate, and is without the unpleasant sequelae d it is which characterize the use of morphine. It neither stupefies nor depresses the patient, but yields all the mild anodyne results without any of the toxic or objectionable phases.

When there is a persistent cough, a constant "hacking," a "tickling" or irritable membrane, accompanied with dyspnoea and a tenacious mucous, the treatment indicated, has no superior. In my experience I found one "Antikamnia & Heroin Tablet" every two or three hours, for an adult, to be the most desirable average dose. For night-coughs, superficial or deep-seated, one tablet on retiring, if allowed to dissolve in the mouth will relieve promptly, and insure a good night's rest. In short, it will be found futile to delve for a more prompt and efficient remedy than "Antikamnia & Heroin Tablets" in all bronchial complications with laryngeal irritation, dyspnoea, asthma, winter-cough and general irritability of the thoracic viscera."

*Qualified Examiner in Nervous and Mental Diseases for Supreme Court, New York City.

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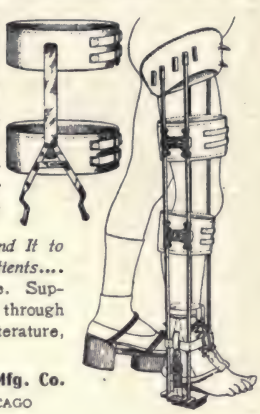

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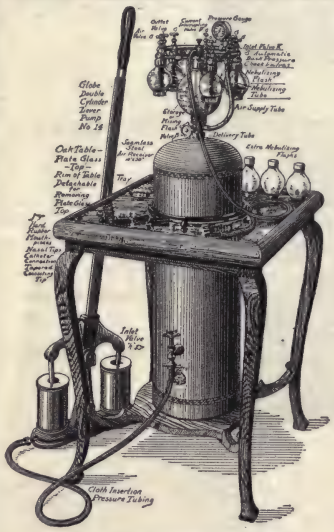

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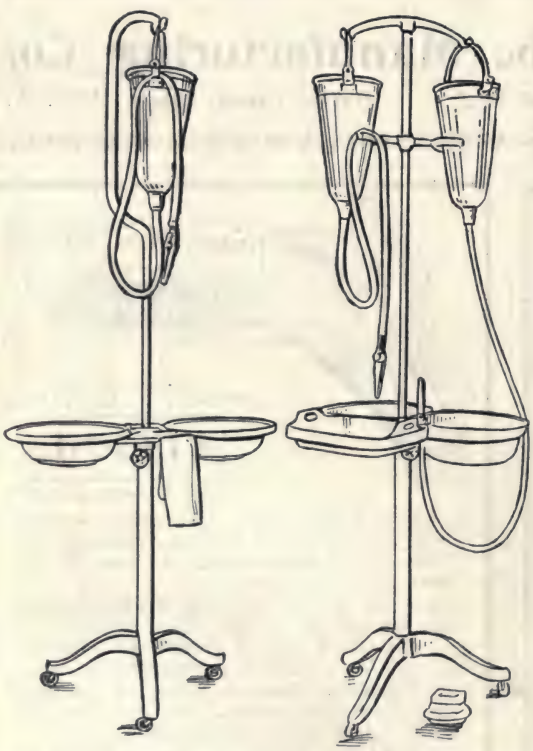

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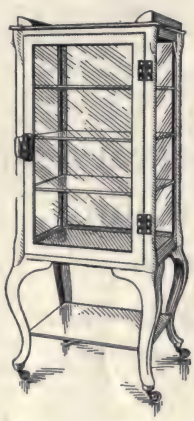

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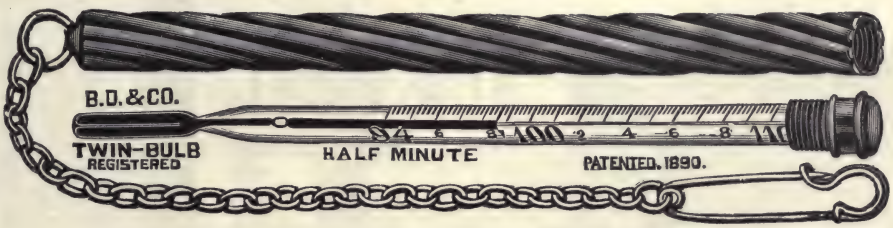

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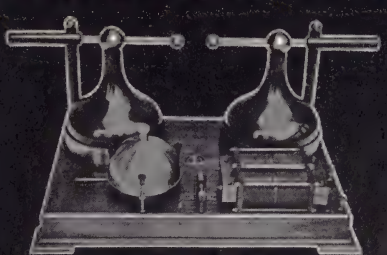

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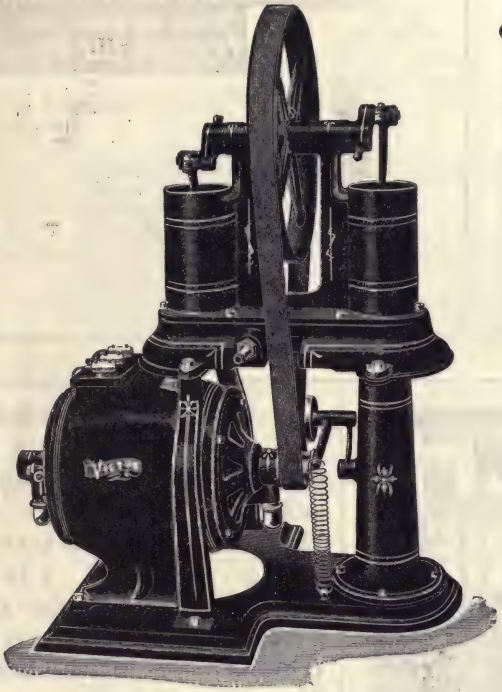

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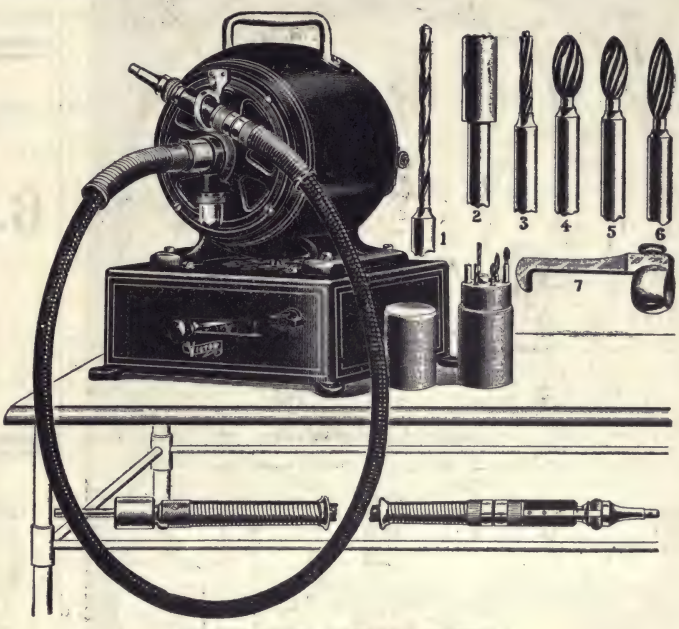

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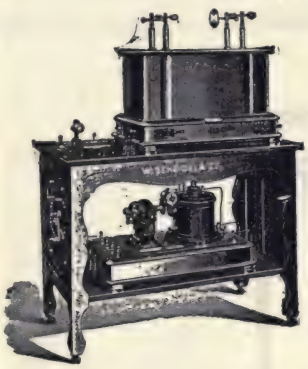

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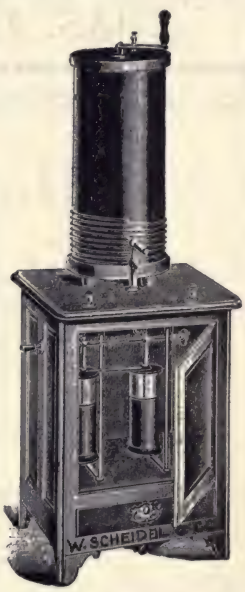

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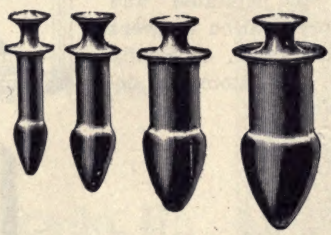

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